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ABSTRACT

The research conducted by the Institute for Interdisciplinary Studies of the American Rehabilitation Foundation is summarized. The first phase of this study is divided into three parts: (1) an examination of all functions that might be engaged in by an information and referral center, (2) an examination of the potential role of an information and referral center to support the process of planning services for the aged population and (3) an integration of the results of the analysis of services and planning as related to information and referral centers into a single model. This report is that integration. (Author/MM)

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INFORMATION AND REFERRAL CENTERS:

A FUNCTIONAL ANALYSIS

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PREFACE

The material in this report was originally developed as a partial requirement of a Title IV grant from the Administration on Aging, H.E.W., covering information and referral centers for the aged.

The scope of the complete grant project is narrower than this report indicates. However, much of the material being developed in reference to information and referral centers for the aged is equally applicable to the development and operation of information and referral centers for any other segment of the population – even for the population as a whole.

As a part of its commitment to share the results of research, the Institute for Interdisciplinary Studies of the American Rehabilitation Foundation conducts a program of publications of generally applicable research findings. This publication is one of the series.

It is believed that much of the information in this report will be of value to state, county, and city authorities interested in, or responsibile for, the establishment or conduct of an information and referral service. This is the first of a series of such publications on this important subject.

Seldon P. Todd, Director
Institute for Interdisciplinary Studies

Acknowledgements

The staff of the information and referral project of the Institute of Interdisciplinary Studies wish to acknowledge the help and cooperation they have received from the many individuals and organizations contacted during the course of this research. We are particularly indebted to the directors and staff of the information and referral centers sponsored by the United Fund and Community Councils in these cities: Dallas, Houston, Los Angeles, Minneapolis, Phoenix, Salt Lake City, and Tucson, who allowed members of our staff to visit and observe the operation of these centers. We thank Mr. Lowell Wright of the national office of the United Way of America and his staff for providing valuable information and reports about the operations of other individual centers. We wish to acknowledge the help of Miss Eleanor Bader, Miss Marilyn Hennessy, Mr. Barry Smith, and Miss Jessamine Cobb of the National Easter Seal Society for Crippled Children and Adults (NESS), in providing us with information about its basic program of information, referral, and follow-up.

Useful consultation and information have been provided by Miss Eileen Lester of the Public Health Service; Dr. Alfred Kahn of the Columbia University School of Social Work; Mrs. Ferne Kolodner and Mr. Lawrence Heber of the Social Security Administration; and Mrs. Joe Graber of the National Center for Health Services. We are particularly indebted to Dr. Leonard Bloksberg, now at the Boston University School of Social Work, for making available to us the results of the "Survey of Information and Referral Services Within the United States," and to Professor Howard Freeman of the Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University for facilitating the receipt of this information. We also thank Mrs. Jessie Gertman and Mr. Byron Gold of the Administration on Aging for their advice and help during the course of this research.

This report is the result of the collective effort of many persons within the Institute for Interdisciplinary Studies. Principal authors are listed on the title page. Dr. Nicholas Long prepared Chapters 1, 2, 3, and 4; (Mrs.) Mary E. Mathis wrote Chapters 5, 6, and 7; Mr. Reginald Burd and Dr. Jacqueline Anderson prepared Chapters 8, 9, and 10; and Chapter 11 was written by Mr. Seldon Todd and Dr. Long.

Table of Contents

Title page ii
Preface iii
Acknowledgements iii
Table of Contents iv
Introduction iv
Chapter 1 – Why Information and Referral Centers? 1
Chapter 2 – Historical Overview of Information and Referral Services 2
Chapter 3 – How Information and Referral Centers Are Set Up 6
Chapter 4 – What Information and Referral Centers Do 12
Chapter 5 – A Study of Need 18
Chapter 6 – Ways to Define Need 22
Chapter 7 – Barriers to Need Satisfaction 24
Chapter 8 – The Planning of Human Services: A Brief Description 26
Chapter 9 – Information and Referral Center Activities for Collecting and Distributing Data .. 30
Chapter 10 – Uses for the Information and Referral Center Data from a Planning Support Function 36
Chapter 11 – The Case for a Network of Information and Referral Centers 37
Appendix 40
Bibliography 42

Introduction

This report summarizes the research conducted by the Institute for Interdisciplinary Studies of the American Rehabilitation Foundation under the first phase of its Administration on Aging Title IV grant, 93-P-75051/5-02, "Information and Referral Center Study." The first phase of this study was divided into three parts: 1) an examination of all functions that might be engaged in by an information and referral center; 2) an examination of the potential role of an information and referral center to support the process of planning services for the aged population; and 3) an integration of the results of the analysis of services and planning as related to information and referral centers into a single model. This report is that integration.

CHAPTER 1

Why Information and Referral Centers?

The basic justification for any social service offered to people is that it provides a significant contribution to their individual needs and the quality of their lives. The point of view established for this study in relation to the potential contribution of information and referral services to older Americans is as follows:

The primary purpose of specialized information and referral centers for the aged is to link older Americans in need of services with the services available in their communities. It is assumed that these services could not be obtained by them without an information and referral center. This statement reflects several distinctions which we feel to be most important. We believe that information and referral centers will not be of significant value unless they furnish a real service which would not otherwise be available. That is, this service should not be merely a convenience which only makes obtaining other services easier. The original study on which this report is based had no direct concern for those older Americans whose needs are currently being met through direct interaction with community services or through other means. The concern was for those elderly individuals who are not effectively connected with the service system at the present time.

It was our conviction and hypothesis in undertaking this study initially, that there are, in fact, many elderly Americans who are in need of services and for whom adequate services exist at the community level, but who have failed to connect with the service system.

Our analysis has strengthened the conviction that a great improvement could be made in the status of the elderly if there were a more effective connection of individuals in this population with services that already exist at the community level. It is also clear, however, that in many cases, services are needed, but, unfortunately, are simply not available at the community level. Consequently, the potential role of information and referral centers in identifying unmet needs and gaps in services for the elderly was also examined. This portion of our analysis essentially represents a concern with problems of increasing or improving the supply of services in relation to need at the community level.

Definition of an Information and Referral Center

Analysis has shown that there are many ongoing activities which are, or can be, referred to as information and referral services. These have different forms, varying from highly organized, well-staffed, autonomous centers to the dispensing of information and advice by various direct service components, such as hospitals, welfare offices, educational institutions, etc. For the purpose of analysis and discussion, therefore, it is important that a clear definition of an information and referral center be presented which, even if arbitrary in some respects, can serve the function of clarifying what is meant throughout the remainder of this report and the analysis that it represents. Although there is no one authority which states these criteria, for the purposes of this report we recommend acceptance of those criteria suggested and utilized by Bloksberg and Caso (1967):

1. The information and referral service must be an organized service.
2. It must have at least one part-time paid staff person working at the serivce.
3. The staff must be formally designated to conduct the service.
4. The agency must maintain an accurate file of agencies and services available in the community.
5. The agency or sub-unit of it must provide information and referral service as its *primary* task [p. 62].

CHAPTER 2

Historical Overview of Information and Referral Services

The purpose of this survey is to give an up-to-date account of what presently exists in the United States in the general service area called "information and referral." This and following chapters describe the number and geographical distribution of agencies offering programs of information and referral; administrative patterns in such agencies; budgetary considerations; staffing patterns; and the functions and activities engaged in by different agencies. A composite information and referral center is described to summarize these facts.

There is a large number of agencies (which come under the auspices of many different organizations) that are called information and referral centers. Because there is no national leadership to coordinate these separate agencies, there is no uniform statement of policy as to what an information and referral service should be or should do. The following overview describes those agencies that directly and indirectly influenced the development of information and referral services in this country.

The Social Service Exchange

In a recent article about Social Services Exchanges, it is stated that they

> were organized to facilitate interagency communication through maintenance of a central confidential file of families and individuals known to social agencies. The exchange had its origins in the charity organization movement in the 1870's. Its earliest purpose was to prevent duplication in relief-giving. During recent decades, in theory at least, its major purpose has been to facilitate clearance and communication among agencies so that professional information can be shared in the interest of effective and co-ordinated service to the client [Williams, 1964, p. 731].

In 1946, there were 320 exchanges in operation in the United States and Canada. By April 1963, the number had dwindled to 97. A variety of reasons is given for closing the exchanges, including changes in casework philospphy; research indicating that communication among agencies upon receipt or registration affected an insignificant proportion of the total cases served; and decline in use by public agencies. Williams (1964) believes that "all of these reasons might be regarded as symptoms of a loss of conviction in the exchange as a necessary instrument in social services [p. 733]."

There are only 40 Social Service Exchanges listed in the "1969 Directory of Social Service Exchanges" (United Community Funds and Councils of America*, 1969). Of these 40 exchanges, eight have the same directors and addresses as do eight information and referral centers listed in the most recent "Directory of Information and Referral Centers" (UCFCA, 1968). Information is insufficient to indicate how many of the current UCFCA information and referral centers trace their history directly back to a Social Service Exchange, but it is obvious from the present relationship between a substantial number of Social Service Exchanges and information and referral centers that there is a very direct link between the two in a significant number of cases.

The Community Advisory Center

Following World War II, the United States Government, through the Retraining and Rehabilitation Administration of the Department of Labor, directed the operation of over 3,000 centers to serve as clearing houses for information, advice, and referral. It was anticipated that they would serve many groups of persons making the transition from war to peacetime, including factory

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* The United Community Funds and Councils of America, Inc., (UCFCA) is now known as the United Way of America.

workers and veterans. However, the major focus of most of these Community Advisory Centers was on the problems of the returning soldier, which is reflected in the fact that the centers were popularly known as Veterans Information Centers. With the transition to peace completed, the majority of these centers shut down by 1949 (Kahn, Grossman, Bandler, Clark, Galkin, & Greenawalt, 1966, pp. 61ff).

The Citizens' Advice Bureau

The Community Advisory Center bore some similarity to the Citizens' Advice Bureau (CAB) which developed in Britain during World War II. These bureaus were established by volunteers to help persons endure through the disruptions of the war, and to deal with the reorganization of their lives after the war. The structure and function of the CAB is discussed in detail in the books *The Story of the Citizens' Advice Bureaux* (Brasnett, 1964) and *Neighborhood Information Centers: A Study and Some Proposals* (Kahn et al., 1966). Its range of functions overlaps considerably with those of present-day American information and referral centers.

Central Information Center for the Chronically Ill

Concurrent with the development of the CAB's and the Community Advisory Centers was that of the Central Information Center for the Chronically Ill. The first of these was established in Chicago in 1944. During the next decade, four more were organized, located in Milwaukee, San Francisco, Cleveland, and Essex County, New Jersey. This specialized service was developed to give accurate information concerning resources to physicians and chronically ill persons or their advocates (Council on Medical Service, 1959a, 1959b, 1959c).

In 1949, the Commission on Chronic Disease was established to document the mounting problem of chronic disease and the case of the long term patient. The Commission's work, plus the recommendations of the 1956 National Health Forum, contributed to the Public Health Service's decision to intensify and expand its Chronic Disease Program in the late 1950's. One facet of this program was to establish information and referral centers to inform the public about health resources in the community.

Further impetus to this program was given by the Community Health Services and Facilities Act of 1961 (Public Law 87-395) which

> provided for "grants to State agencies or to other public or non-profit agencies or organizations for studies, experiments, and demonstrations looking toward the development of new or improved methods of providing health services outside the hospital, particularly for chronically ill and aged persons." . . . The authority lasted for six years from fiscal year 1962 through fiscal year 1967 [Department of Health, Education, and Welfare, 1967, "Introduction"].

Twenty-eight grants were given under the broad area of activity called "Information and Referral" during the six year period. An additional ten projects, listed under other areas of activity, had large investments in the area of information and referral.

The interest of the Public Health Service in information and referral services led, in May 1965, to a contract to the Florence Heller Graduate School for Advanced Studies in Social Welfare of the Brandeis University to conduct a comprehensive study to identify and describe all information and referral centers in the United States. The final report of this study was submitted to the Public Health Service in September 1967, but the results of the study have not been published to date. According to their findings, the first information and referral service began operation in 1877. During the period 1877-1945, a total of 44 information and referral centers was begun. By the end of 1966, there was a total of 269 information and referral centers in operation. Of these, 118 indicated that they offered a general service, with the remaining centers offering only a limited or specialized service. This limited service might be restricted to providing information about alcoholism, mental illness, or health problems only, for example. Much of the subsequent material in this chapter is drawn from this report. Although the data are no longer current, they remain the most comprehensive to date.

The United Community Funds and Councils of America

Although some information and referral centers existed under the auspices of the predecessors of the present United Community Funds and Councils of America (UCFCA) as early as 1921, the majority began during World War II (Fraser, 1969). These centers evolved in order to serve mothers who were forced to go to work because of the war. During the 1940's and 1950's, approximately 20 centers came into existence; at the present time, according to the most recent "Directory of Information and Referral Centers," there are 48 centers in the United States, with an additional six in Canada.* Although the focus of these centers generally has been on giving information about social welfare resources, with the development of the Public Health Service Chronic Disease Program the UCFCA information and referral centers began to expand their area of interest to include specialized information in the fields of health and aging as well (Miss Eileen Lester, personal communication, November 13, 1969). In fact, some of the Public Health Service information and referral demonstration projects were conducted by UCFCA sponsored services.

The National Easter Seal Society for Crippled Children and Adults

In 1962, the National Easter Seal Society for Crippled Children and Adults (NESS) began a self-study of all aspects of that organization with the help of researchers from the Massachusetts Institute of Technology. Among the recommendations made at the conclusion of the study in 1964 was that one basic program was needed which would be carried out by all affiliates of the NESS, and by which each affiliate would be identified with the national program. The basic program recommended for the NESS and its affiliates is described in the following resolution, which was passed by the House of Delegates of the NESS in November 1966:

BASIC PROGRAM

> That the House of Delegates adopt as the basic Program of the Easter Seal Societies a service of information, referral and follow-up aimed at helping disabled persons *find* and *make effective use* of available resources which will help them develop their abilities and live purposeful lives; and further
>
> That the Basic Program be made a requirement of membership for all affiliates effective with the adoption of it as a policy, with the expectation that implementation would begin immediately and proceed as rapidly as possible [Proceedings of the House of Delegates of the National Society for Crippled Children and Adults, November 1966].

Although there has been a steady move toward implementation of the basic program by the affiliates since the passing of the resolution, total implementation has not yet been accomplished. There is no data available at this time as to how many affiliates have actually put the basic program into operation, or how near they are to achieving this goal. The most recent NESS "Directory of Local Affiliates" lists 280 agencies located in 30 states. In addition to the local affiliates, there are 52 intermediary societies (including the District of Columbia and Puerto Rico), and the National Society in Chicago, Illinois. The potential number of Easter Seal Society Information, Referral and Follow-up Centers is about 330.

Although the resolution emphasized helping disabled persons, in practice the goals of the NESS are broader than this. The NESS sees this restricted role as appropriate for those affiliates which are located in areas where there are other information and referral centers which provide a good general service, or where there are many specialized services. Where such specialized information services or general centers do not exist, the NESS affiliate will attempt to provide a spectrum of information services comparable to those offered by a general service, with special follow-up services to the disabled (Miss Marilyn Hennessy, personal communication, December 5, 1969). The key principle

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* A new "Directory of Information and Referral Centers" has been issued recently by the United Way of America (formerly the UCFCA), listing 57 centers in the United States and seven in Canada.

that governs the scope of service of an individual NESS affiliate is cooperation with the existing structure of information and referral services in a given community. The goal of the NESS is to ensure the provision of the most comprehensive information service, with a minimum of duplication of the work of other agencies.

The Administration on Aging (AoA)

Under Title III of the Older Americans Act of 1965, provision is made for matching federal grants to be given to state-approved projects concerned with the delivery of services to the aged. In an anonymous, undated report titled "Programs on Aging Information and Referral Services," 637 Title III projects are mentioned, of which 287 have some sort of information and referral component. Material for this report is based on a review of project proposals and reports of progress through December 31, 1967. Although this report is now out of date, it does give some idea of the magnitude of information and referral services under these auspices. In an evaluation of these information and referral services it is stated that in many instances

> it is clear that the grantees did not conceive the essential elements, nor did the State agencies generally insist on assurance that the grantees knew what was involved. Generally, the extent to which intentions of providing information and referral services were made known was by a simple objective, such as "we will provide an information and referral service" period [AoA, 1968, p.7].

The scope of such projects is great, however, and these comments would not be appropriate for all Title III projects having an information and referral component. For example, in the State of Minnesota, the AoA sponsored a project titled "Information and Referral Specialist on Aging and Chronic Illness," which ran for the period 1967 through 1969. This is the project description:

> Provided for two persons to serve as Information and Referral Specialists in providing information and help to older persons with problems. New informational material on resources available was also developed. [Minnesota Governor's Citizens Council on Aging, 1970b, p.1].

This project was conducted in a United Fund sponsored information and referral center. Another Minnesota Title III project running for the three-year period beginning July 1967, named "Winona Center for Older Adults," is described in this way: "Provides for a senior center which will provide a comprehensive program of recreational and social activities, education, information and referral service and counseling for older adults [Minnesota Governor's Citizens Council on Aging, 1970a, p.2]." It is apparent that the scope of these two programs is different, and that the emphasis on "information and referral" services is not quite the same in these two cases.

Other Information and Referral Programs

Our research indicates that many other agencies and organizations provide some kind of service (through their affiliates) that is often designated "information and referral." Churches, labor unions, and the Office of Economic Opportunity, to name a few, have offices or agencies under their auspices which provide "information and referral services." The proliferation of information and referral services is documented and discussed fully by Fraser (1969).

CHAPTER 3

How Information and Referral Centers Are Set Up

The following materials are drawn from the "Final Report to the Public Health Service" of the Brandeis University study team's "Survey of Information and Referral Services Existing Within the United States" (Bloksberg & Caso, 1967). Since the data are now several years old, they should be viewed as approximate. The information does, however, indicate trends and some basic characteristics.

General Characteristics

The distribution by state of information and referral centers identified by Bloksberg and Caso is given in Table 1, Column 2. (The centers listed in the other columns are presented for ease of comparison. Some of these other centers may be included among those listed in Column 2.) Classification by the Census Bureau's regional classification system indicates fairly even distribution across the New England and Middle Atlantic states, the East and West North Central states, and the South; each of these three regions had approximately 27% of the information and referral services. The Mountain and Pacific states had only 19% of the total.

The year that an agency service began is given in Table 2. Of the 23 agencies providing specialized services for the aging, only one began prior to 1956. Over 65% of the total 269 agencies began operations in 1955 or later. Although specialized agencies were relatively few before 1956, over 53% of the total number are now "specialized" rather than "general" agencies. Data concerning these specialized agencies were tabulated separately, using these categories: Aged Only; Aged and Chronically Ill; Aged and Other: Chronically Ill Only; Health; Mental Illness; and Alcoholism. A variety of other specialized agencies, including: legal; suicide prevention; mental retardation; speech and hearing, were not analyzed separately, but were grouped together under the heading "Other." There was a total of 24 agencies in this category.

Administrative Patterns

Over 70% of the reporting agencies classified themselves as nongovernmental, receiving 25% or less of their 1966 operating budget from governmental sources. An additional 13% classified themselves as nongovernmental, but received more than 25% of their 1966 operating budget from governmental sources. Only 16% of the agencies were under governmental auspices. Agencies dealing with the aged population were more likely to be under governmental auspices than other specialized centers. Over 75% of all the reporting information and referral centers indicated organizational dependence or integration within a larger service. Five of the nine centers serving only the aged classified themselves as independent, but of the remaining 14 centers serving the aged and the chronically ill or other groups, only two indicated independence from other services (Bloksberg & Caso, 1967, p. 25). Data are not available at this time with regard to the details of the sources of funds for budgets.

With regard to the chief administrator of information and referral centers, almost 70% had the title of Director. The remainder had various titles denoting lesser status, such as Supervisor or Administrator in Charge (Bloksberg & Caso, 1967, p. 37). Directors headed 15 of 21 agencies serving the elderly. Forty percent of all chief administrators were accountable to their own policy-making board, although only one of the nine administrators of agencies serving the aged and chronically ill was accountable to his own board. The remaining 60% of all administrators were accountable to the administrator of the parent agency or some division of the parent agency (Bloksberg & Caso, 1967, p. 39). Although data were gathered on how policy decisions were made for the individual information and referral centers, this information was not reported.

TABLE 1

AGENCIES PROVIDING INFORMATION AND REFERRAL SERVICES

State	Social Security Offices[a]	Brandeis Study[b]	NESS[c]	UCFCA[d]	Title III AoA Projects[e]	Social Service Exchanges[f]	Senior Citizens Centers With I & R[g]
Alabama	17	3	16	0	0	0	3
Alaska	2	0	7	0	1	0	0
Arizona	5	2	2	2	7	0	1
Arkansas	12	6	1	0	8	1	4
California	63	30	25	3	52	1	30
Colorado	11	2	8	1	13	0	5
Connecticut	12	6	8	2	8	0	13
Delaware	2	3	1	0	5	0	6
D. C., Wash.	6	2	1	1	2	0	10
Florida	31	8	15	1	13	0	16
Georgia	21	0	4	2	10	0	8
Hawaii	4	3	4	0	7	0	1
Idaho	6	0	1	0	6	0	0
Illinois	36	5	16	1	23	1	40
Indiana	20	12	10	1	0	1	8
Iowa	11	2	4	0	16	2	11
Kansas	10	3	1	0	3	0	1
Kentucky	19	0	5	0	14	1	8
Louisiana	14	3	2	1	15	0	3
Maine	6	6	1	0	17	1	4
Maryland	17	5	7	1	17	0	6
Massachusetts	26	7	1	1	18	1	19
Michigan	30	13	14	4	21	2	24
Minnesota	12	4	1	1	20	0	18
Mississippi	14	2	2	0	0	0	0
Missouri	22	7	7	2	5	0	6
Montana	7	1	1	0	10	0	1
Nebraska	8	2	1	0	6	0	4
Nevada	2	0	2	0	0	0	0
New Hampshire	6	0	3	0	3	1	1
New Jersey	17	7	5	1	16	1	21
New Mexico	6	3	1	1	8	0	4
New York	55	40	9	4	22	4	138
North Carolina	26	3	8	0	10	0	6
North Dakota	4	1	1	0	1	0	6
Ohio	38	14	32	5	11	14	31

State	Social Security Offices[a]	Brandeis Study[b]	NESS[c]	UCFCA[d]	Title III AoA Projects[e]	Social Service Exchanges[f]	Senior Citizens Centers With I & R[g]
Oklahoma	12	6	1	2	8	0	7
Oregon	9	0	1	1	18	0	3
Pennsylvania	45	5	51	2	18	6	42
Rhode Island	3	1	1	1	3	1	6
South Carolina	13	4	9	1	4	0	2
South Dakota	4	0	1	0	2	0	2
Tennessee	20	3	5	0	7	0	6
Texas	43	17	21	2	7	1	16
Utah	3	1	1	1	2	0	5
Vermont	3	0	1	0	13	0	7
Virginia	16	5	1	1	5	0	4
Washington	12	9	3	1	20	0	9
West Virginia	11	2	5	0	8	0	2
Wisconsin	20	10	2	1	14	1	9
Wyoming	3	1	1	0	0	0	0
TOTAL	815	269	331	48	517	40	577

[a] Social Security Administration Offices. "Social Security Administration Service Area Directory," September, 1969.

[b] Bloksberg & Caso, 1967, p. 10f.

[c] National Easter Seal Society for Crippled Children and Adults. 1) "Directory of Local Affiliates" and 2) "Directory of State Societies for Crippled Children and Adults." (Undated, c.1969).

[d] United Community Funds and Councils of America, Inc. "Directory of Information and Referral Centers." August, 1968.

[e] Administration on Aging. Derived from AoA 309, a form for "Report on Project Operations for Projects Funded Under Title III of the Older Americans Act."

[f] United Community Funds and Councils of America. "1969 Directory of Social Service Exchanges in the United States and Canada." New York: United Community Funds and Councils of America, 1969 .

[g] Institute for Interdisciplinary Studies. "Senior Centers: A National Directory." Minneapolis: American Rehabilitation Foundations, 1969. (All Senior Centers listed in this directory, which are listed as providing "information and referral" in their program of activities are included in the tally under the column "With I & R."

TABLE 2

YEAR SERVICE BEGAN[a]

Year Service Began	Aged Only %	Aged and Other %	Aged and Chronically Ill %	General %	%	Total N
1877-1945	0.0	20.0	0.0	30.0	17.3	44
1946-1955	0.0	0.0	0.0	19.5	17.3	44
1956-1958	22.2	20.0	22.2	8.5	13.8	35
1959-1961	0.0	0.0	11.1	8.5	13.4	34
1962-1964	44.4	40.0	55.5	14.4	19.3	49
1965-1966	33.3	20.0	11.1	18.6	18.9	48
N=	9	5	9	118		254[b]

a This table is adapted from Bloksberg & Caso (1967, p. 21).

b This figure represents the total number of centers in the survey responding to this item. (Figures for 113 other specialized centers are omitted from the body of the above table.)

Patterns of Staffing

Although the questionnaire used by Bloksberg and Caso included a comprehensive section on staffing, including items relating to directors, supervisors, staff workers, consultants, secretaries, and telephone operators, only information about the directors of the agencies was reported. Questions asked included what level of service was offered by the staff person (e.g. information only, referral, counseling), educational level and professional identity of the staff person, and whether he was employed full-time or part-time. Approximately 32% of agency administrators had the Master of Social Work degree. An additional 16% were identified as social workers, but with academic training of less than M.S.W. Slightly less than 10% of all administrators were identified as nurses or health educators. The level of education and professional identity of the remaining 42% of the administrators was not discussed. Nothing was reported about the level of service provided by the administrators.

Slightly less than 30% of the agencies reported using volunteers on their staff. Four of seven agencies serving only the aged made use of volunteers, while of the 13 agencies serving the aged and chronically ill or aged and other, only one had volunteers on its staff. Nothing was reported about the activities performed by these volunteers.

Approximately 20% of the centers served populations of less than 100,000. Approximately 17% of the centers served populations of over 1,500,000. Centers serving the elderly were found to be located, generally, in larger population areas. The size of populations served by the different centers is given in Table 3.

TABLE 3

POPULATION SIZE SERVED BY DIFFERENT I & R CENTERS[a]

Population (in 1000's)	Aged Only	Aged and Other	Aged and Chronically Ill	General	Total	
	%	%	%	%	%	N
Less than 100	22.2	25.0	11.1	22.3	19.3	49
100-199	22.2	0.0	11.1	11.6	15.4	39
200-349	11.1	0.0	0.0	16.5	15.0	38
350-699	11.1	25.0	22.2	18.2	16.1	41
700-1499	33.3	25.0	33.3	14.9	16.9	43
More than 1500	0.0	25.0	22.2	16.5	17.3	44
N =	9	4	9	121		254[b]

a This table is adapted from Bloksberg and Caso (1967, p. 23).

b This figure represents the total number of centers in the survey responding to this item. (Details are given in this adaptation only for those classified as serving the aged or as general centers.)

In the "Summary of Service Statistics of Community Information and Referral Centers, 1962" (UCFCA, 1963) data about 23 UCFCA information and referral centers are given. According to the data in this summary, the number of professional staff members per 100,000 population ranged from 0.03 to 0.30, and averaged 0.11. The number of staff workers in a single center ranged from one quarter-time person to 8.12 persons. The average number of workers per center was 2.6. There were two or three professional workers for each clerical worker. Volunteers were used in only 25% of the centers, and in only two of the centers was the number of volunteers equal to one or more full-time persons. Based on our own research, these figures seem fairly representative of many information and referral centers at the present time.

Characteristics of Persons Using Information and Referral Centers

One hundred ninety-six agencies reported the total number of requests for service that they received during the year 1965 in the Bloksberg and Caso study. The survey information suggests that centers serving the aged tended to receive more requests for information than other specialized centers. However, this may be due, in part, to the location of these centers in more densely populated areas. The number of requests for service received by various agencies during 1965 is presented in Table 4. These figures are similar to those reported by the UCFCA (1963), where the average annual number of inquiries was about 290 per 100,000 population, with a range of 60 to 1,612 inquiries per 100,000.

TABLE 4

REQUESTS FOR SERVICE DURING 1965 IN VARIOUS CENTERS[a]

Requests	Aged Only	Aged and Other	Aged and Chronically Ill	General	Total	
	%	%	%	%	%	N
Less than 250	0.0	0.0	12.5	18.9	19.4	38
250-749	50.0	25.0	50.0	26.7	32.7	64
750-1499	16.7	0.0	12.5	18.9	17.4	34
1500-2999	16.7	25.0	0.0	8.9	10.7	21
3000-4999	0.0	50.0	0.0	8.9	6.6	13
5000 or more	16.7	0.0	25.0	17.8	13.3	26
N=	6	4	8	90		196[b]

a This table is adapted from Bloksberg and Caso (1967, p. 24).

b This figure represents the total number of centers in the survey responding to this item. (Details are given in this adaptation only for those classified as serving the aged or as general centers.)

The UCFCA reported that over 68% of all inquiries were made by the general public. This figure is similar to that reported by Bloksberg and Caso (1967, p. 31), where almost half of the reporting agencies indicated that 60% or more of all requests for assistance came directly from the client or his agent (exclusive of private, professional persons or other agencies). Less than 30% of all requests were made by other agencies or private professionals in over 75% of the reporting agencies. It is apparent that the major user of an information and referral service is the private citizen. The UCFCA reported that 70% of the private citizens contacting information and referral services were unknown to the service prior to contact. In a study conducted by one information and referral center serving the aged and chronically ill, measures were taken on prior contact with the entire health and welfare system in the community. It was found that 17% of the clients had had no prior contact with any element of the system, and that 34% had contacted only one resource (Sigler, 1967, p. 74). Thus, generally speaking, information and referral centers seem to be reaching the population they intend to serve: namely, those persons who have not previously used the service system.

The UCFCA reported that an average of 90% of all inquiries were made by telephone, with a range from 55.7% to 96.5% of all inquiries made this way. Less than 8% of the inquiries were made by the client, or his agent, in person. The figures reported by Bloksberg and Caso (1967, p. 34) are similar: almost 70% of the agencies indicated that 60% or more of the inquiries were made by telephone. However, of the 18 reporting agencies which provide help to the aged, all indicated that 25% or more of their contacts came through personal visits from the client or his agent. No explanation is given for this increase in personal visits to these specialized centers. In an experimental study in which trained, mature volunteers were placed in public housing complexes, similar, but more striking, findings were reported. Of the 754 initial contacts with elderly tenants, only 15% were made by telephone; office visits constituted 20% of the total; and field visits, in the tenant's home accounted for 62% of the contacts (Senior Advisory Service for Public Housing Tenants, 1968, p. 7). It is stressed that 87% of the total target population were actually contacted, and that this high percentage of coverage was the result of the outreach effort: 77% of all initial contacts were initiated by the service workers (Senior Advisory Service, 1968, p. 3).

In the UCFCA sample, over 65% of all inquiries were handled by giving information, guidance, or direction only. In the Bloksberg and Caso (1967, p. 35) study, 31% of the reporting agencies indicated that over 50% of their inquiries were handled by giving information only; in an additional 32% of the agencies over 50% of all inquiries were handled by referral (although it was not specified how intensive the referral procedure was). Thus, over 60% of the reporting agencies indicated that over 50% of their cases were handled by information and referral only. In the previously cited study (Senior Advisory Service, 1968, p. 11), 45% of all cases were handled by information giving, steering, or referral.

CHAPTER 4

What Information and Referral Centers Do

One may conceptualize the functions of most information and referral services under five primary areas: resource file development and maintenance, direct service, publicity, outreach, and participation in the planning of services. Under each of these functions, a variety of activities may be carried out. In the following sections, the major activities carried out under each function are summarized.

Resource File Development and Maintenance

The development of a resource file requires the systematic gathering of pertinent information about a community's health, medical, welfare, social service, educational, and recreational resources. Depending on limitations in the scope of the information and referral service, data concerning all of these resources may not be collected. The activities required in developing a resource file generally involve a personal interview with the administrators of all resource agencies of interest. Although contact by telephone or letter is a possibility, this method is generally not used. The reason given is that it does not usually permit establishing a working relationship with the agency administrator. (Implicit in this belief is the quasi-political notion that the referral process is facilitated if a personal relationship exists between the interacting professional persons. This notion seems all too often to be true. The newspaper column reproduced in the Appendix documents the problems that even a professional person can have in trying to make a referral within a service system. Although information and referral services ostensibly are conceived to help prevent the kind of difficulties described in this column, it is obvious that in this particular instance, the information and referral center was no better or worse than any of the other ten agencies involved. While the recommendation to contact agency heads personally is obviously sound advice, it is also a tacit indictment of the service system within which they operate. Without some kind of accountability in the system, it is unlikely that the unprofessional Realpolitik of the system will be eliminated.)

Where the potential number of resource agencies is large, this process can take many months to accomplish. For example, in one project, six months were required to obtain information for a resource file of approximately 265 agencies (Sigler, 1964, p. 2). Another project used seven months, from the time it was funded to the time it began operation, to develop a resource file on over 700 agencies (Hampton Roads Health Information-Referral Planning Center, 1968, pp. 2, 14). In yet another project, the development of the resource file was cited as one of the major problems encountered in setting up the information and referral service:

> Staff would recommend to any community considering establishing an Information and Referral Service whether it be specifically for the aged or comprehensive, that they

include money in the budget for establishing an up-to-date resource file and allow for a period of from three to six months to be used specifically for this purpose [Health and Welfare Council of Metropolitan St. Louis, 1967, p. 17].

Obviously, the exact amount of time required to develop the resource file will depend on how many agencies actually have to be contacted. The number of agencies known to the information and referral services reporting in the study conducted by Bloksberg and Caso is given in Table 1. It can be seen from this table that almost 40% of the reporting agencies knew of less than 55 other community agencies. Over 30%, however, were aware of 145 agencies, or more.

TABLE 1

NUMBER OF AGENCIES KNOWN TO INFORMATION AND REFERRAL CENTERS[a]

Agencies Known to I & R for Possible Use	Aged Only	Aged and Other	Aged and Chronically Ill	General	Total	
	%	%	%	%	%	N
Less than 55	28.6	100.0	33.3	18.3	38.3	82
55-144	57.1	0.0	16.7	36.7	29.4	63
145 or more	14.3	0.0	50.0	44.9	32.2	69
N=	7	3	6	109	99.9	214[b]

a This table is adapted from Bloksberg and Caso (1967, p. 45).

b This figure represents the total number of centers in the survey responding to this item. (Details are given in this adaptation only for those classified as serving the aged or as general centers.)

In addition to developing the resource file, there is an ongoing process of updating and revising it. This is accomplished in a variety of ways, from relatively informal revisions based on new information gained through direct service activities, such as referring a client and talking to someone at the agency in the process, to formal procedures for routine contact by mail carried out on a monthly, quarterly, or annual basis. However, in the survey conducted by Bloksberg and Caso, it was found that over 34% of the information and referral centers maintained contact with less than 50% of the community agencies known to them. General centers and those serving the aged and chronically ill were more likely to maintain contact with a greater number of agencies.

There has been some experimentation with the use of computers to store and retrieve information for the resource file, but to date no satisfactory system has been developed to do this (Fraser, 1969). The major problem seems to be in translating the more "personal" kinds of data that are often contained in resource files into a format that can be handled by a computer.

Direct Service

Direct service activities are generally classified into four areas: giving of *information* only, which may range from providing a telephone number to explaining eligibility requirements for receiving aid of a certain kind; *referral,* which may range from what is called "steering" or "direction" to a relatively active process of making appointments for the client at other agencies, even to providing supportive activities such as taking the person to his appointment; *follow-up,* which can include contacting the agency to see if the individual kept his appointment, or contacting the client to see if he went to the agency; it may also include an inquiry as to whether or not he was satisfied with the service he received; and a final area of importance, the provision of *counseling* services. Although this service is usually provided to help the client clarify the sort of help or information he needs, it often borders on casework services that are provided by other agencies.

With the exception of pure information-giving, each of these areas has a certain amount of controversy associated with it. In the case of referral, some community agencies view this activity with suspicion, for they believe that it reduces the motivation of the client to obtain services for himself. They also feel that by making an active referral, the information center has begun to establish a relationship with the client which will impede his developing such a relationship with the staff person at the new agency.

In one report, the following is said about referral:

> . . . in actual practice few agencies would accept a direct referral from the Centre. . . . Most agencies preferred that the applicant prove his motivation by asking personally for service rather than through the counsellor at the Centre [Community Services Centre, 1968, p. 3].

In this report, referral is defined relatively narrowly:

> A referral in the strictest sense of the word would involve the Centre taking an active part in making an appointment with the resource agency and then providing the agency with data about the applicant and his problem [Community Services Centre, 1968, p.3].

In another report, in a discussion of the referral process, the following is observed: ". . . staff came to see that in some respects their operation was comparable to that of a screening or intake process [Sigler 1967, p. 18]." But in yet another report, this finding is recorded: "The I & R Service should not undertake responsibilities that are properly the function of casework agencies or of the Intake Department of other types of agencies [Bay Area Welfare Planning Federation, 1967, p. 62]."

In one paper in which the referral process is examined in detail, other points emerge. One concerns the lack of definition of "referral." The author points out that it was impossible to obtain quantitative information on referrals by different agencies in the community, ". . . mainly due to differences in definitions as to what actually constitutes a referral [Smith, 1963, p. 6]." A second point concerns the relationship of referral to counseling or direct service. This same author

> . . . seriously question[s] that I & R centers can adequately perform a referral function without appreciation of the needed time and immediate accessibility to [clients] . . . over successive contacts. This will entail expansion of our present function of only brief contact service to one of extended contacts in needed situations. This would require community and agency acceptance of a direct service role for I & R Centers [Smith, 1963, p. 8f].

What is clearly needed is a careful research effort to determine the relative effectiveness of different kinds of referral procedures, as well as the general utility of the referral process itself. Such a study would have to be structured so that comparisons could be made between clients receiving referral services of varying degrees of activeness and those not receiving such services, so that a determination could be made about the effect referral has on a client's motivation to follow through. On the surface, it would seem that by placing the burden for motivation on a relatively helpless individual, the effect would be to discriminate against those most in need of help and least able to obtain it.

Follow-up is even more controversial, for it may suggest an information service's evaluating the performance of other agencies. As was mentioned above, this procedure can involve contacting either the agency or the client. Inter-agency referral forms are utilized by about 25% of the agencies reporting this information, according to Bloksberg and Caso (1967, p. 57). Approximately 33% of those agencies indicated that they contacted the community agency to which the client had been referred. No information was given, however, as to what proportion of their cases received this follow-up service. No information was given about the number of agencies that contacted the client directly. The National Easter Seal Society stresses the importance of the follow-up component in its program, which is emphasized by the official designation of their affiliates as an "Easter Seal Society Information, Referral, and Follow-up Center."

Counseling (diagnostic casework and/or treatment) is perhaps the most controversial of direct service activities that may be performed by an information and referral center. There are widely varying opinions on whether this activity is appropriate, and to what degree it should be engaged in by the staff of an information and referral center.

The previous citation from Smith, for example, suggests what is tantamount to a counseling function for the information and referral center. He does observe that this would involve gaining acceptance from other direct service agencies as a prerequisite. Others have found this to be

> . . . an area of considerable sensitivity, as was revealed in information supplied by I & R services in major cities throughout the country. Problems have arisen in some communities because some of the direct service agencies were concerned that the local I & R Service went beyond "a definition of the problem and the needs, with a concurrent effort to evaluate the best resources for meeting those needs" and actually engaged in diagnostic casework service or short-term treatment – a practice which they considered detrimental to the development of their own later relationships. . . [Bay Area Welfare Planning Federation, 1965, p. 44].

In describing its activities, another information and referral center states that

> . . . casework is never done, the philosophy of the Center's policy holding that the Health Information-Referral Center should never duplicate direct services that are provided in the area but should function strictly in a communications and coordination role. . . [Hampton Roads Health Information-Referral Planning Center, 1968, p. 5].

There are a variety of other direct service activities that are performed by some information and referral centers. These include conducting holiday or Christmas clearing houses and operating volunteer bureaus. Of those centers responding in the survey by Bloksberg and Caso, only 48% indicated that they engaged in these other direct service activities. Only eight of the 21 reporting centers which serve the aged indicated that they engaged in these other activities (Bloksberg and Caso, 1967, p. 59f).

Publicity

Historically, the major purpose of publicity has been to create visibility for the information and referral center in the community. A frequent consequence of publicity is an increased demand for services. The range of activities conducted under this function include participating in interviews on local radio and television programs; interviews for newspaper articles and features about the service; preparing and distributing directories listing the various services contained in the resource files; and "consultation." Most frequently, consultation involves the presentation of in-service training programs for special groups such as the local police force, social workers in the community, doctors, lawyers, ministers, and other agencies.

Little is actually known about the most effective way to gain publicity, although many programs report a variety of experiences with efforts in this area. The use of the various mass media is an interesting and important field that should be developed by information and referral centers. There is a considerable amount of wariness with regard to the use of media, for many information and referral services have been literally swamped after a Sunday newspaper article or a television program about the service. Little is known about the differential effect of various media on the

particular populations that an information and referral center may wish to reach. Experimentation with publicity through the use of mass media inevitably affects the other service agencies in the community, and thus becomes an even more complex problem in terms of relations between these agencies and the information and referral center.

The distinction is usually not made between "publicity" and "advertising." In the case of publicity, little can be done to control the nature of the output. That is, an interview can be given, but little can be done to edit the reporter's story or control when the article will appear. The advantage of publicity is that it is usually free. Advertising, on the other hand, most often costs money. But it has the advantage of being tailored for specific needs and requirements.

Outreach

Some agencies see active programs of research into areas of need and the characteristics of the population they serve as important activities to be conducted by the center. The program of an information and referral service located in South Bend, Indiana, is described in some detail in their final report (REAL Services, 1969). Results are presented of a two-year project in which several hundred home interviews were conducted to determine the needs and resources for the older population in St. Joseph County, Indiana. Another study of this kind has just been completed by the Social Planning Council of Saskatoon, Saskatchewan in Canada (Orris, 1970). The study was designed to examine those factors which affect the social and economic independence of people over sixty. In the case of this planning council, the information and referral center is an integral part of the structure and was responsible for the conduct of the study. Future studies are planned by this planning council to test various techniques (passive, advocate, and responsive methods) for providing information to the aged. The design includes the operation of a highly advertised store front center; the use of teams of detached community workers; and the use of teams of workers who screen telephone calls and then go out to visit elderly persons with complex problems which cannot be resolved over the telephone (Mr. Douglas M. Thomas, personal communication, October 20, 1969).

The information and referral service of the Community Council of Greater New York has just completed an interesting, but more specialized, study (Putter & Malzberg, 1969) to determine the effectiveness of an information and referral service in helping the elderly population having home-health and housing needs. Baseline data on requests for information were collected during a six-week period to determine the volume in these areas. During the next year, follow-up contacts were made on all requests for help in either of these areas to determine the usefulness of the information and referral service in helping the individual solve his home-health and housing problem. The findings suggest that the home-health service delivery system was so complex that an information and referral service could have a significant effect in helping aged persons obtain services. Housing services, however, were relatively centralized, so that it is believed that an information and referral service would have relatively little impact in improving service in this area. The research also indicated large gaps in the service delivery system in both areas; recommendations for improving the systems and closing the gaps were made.

Participation in the Planning of Services

Of the centers reporting in the survey conducted by Bloksberg and Caso (1967, p. 59), almost 85% indicated that they attempted to identify resources which were not available in the community (i.e. "gaps in the service system"). Over 88% indicated that they attempted to communicate information about needed services to planning groups within their community, or to provide some consultation to community agencies about the services needed.

One way in which some agencies participated in the planning process was through the collection and recording of pertinent data relevant to the appropriate planning body. However, approximately 12% of the agencies surveyed indicated that they kept no service records on individuals who contacted the agency. Twenty-four percent maintained only summary records on client characteristics, while over 64% kept individual service records on clients requesting help (Bloksberg & Caso, 1967, p. 50).

The dimensions on which statistical data were regularly compiled by these agencies (Bloksberg & Caso, 1967, p. 55) included:

1) 90.4% Type of service requested
2) 88.4% Agency to which client was referred
3) 87.5% How the client contacted the agency
4) 80.8% Client characteristics (all clients contacting the center)
   [E.g. a. Sex
   b. Age
   c. Occupation
   d. Address
   e. Living arrangements
   f. Income level]
5) 78.2% Activity performed by information and referral center prior to making a referral
6) 74.9% Source from which client learned about information and referral agency
7) 73.1% Data on persons contacting the center by telephone
8) 70.0% Whether client went to agency to which referred.

Other activities conducted under support to planning activities include: collecting and reviewing reports from other service agencies; providing reports to other agencies of statistical data on hand, upon request; conducting surveys. There is increasing emphasis being placed on the role of information and referral centers in providing support to the planning function, particularly among Canadian information and referral centers.

In one report, for example, the following is stated:

> . . . the [information] service should be intimately connected to the planning function inasmuch as needs identified and documented by the information service are useful data; the need to have a strong relationship with the Department of Research and Development of the Council is also an argument in support of an administrative tie-in, to the extent that feedback, analysis, and application of findings are aided and enriched by the liaison. . . It is recommended that the Department of Research and Development, being in a strategic position to assist the information service in improving and continuously assessing feed-back techniques and analysing data which are basic to improvement of the information service. . . should exploit this position to the fullest extent possible [Bellamy, 1968, p. 69].

A planning function is explicitly described by at least one American information and referral center, which explicitly states the objective:

> To obtain information through an economical and efficient method of compiling data which will lead toward a more rational approach for the planning of community health services within a metropolitan framework [Hampton Roads Health Information-Referral Planning Center, 1968, p. iii].

In fact this center actually includes "planning" in its title, and indeed, a large portion of its activities are directed toward this end.

Summary: The Composite Information and Referral Service

The composite information and referral center is more likely to be located east of the Mississippi River in a community of 100,000 or more people. The center is a relatively new agency in the community's service system, often no more than five years old, and very likely not more than 15 years old.

The agency is under the auspices of non-governmental organizations, and receives most of its operating budget from non-governmental sources. The information and referral center is most likely to be integrated with a larger service or to have organizational dependence on a larger service. The administrator of the agency has the title of "Director," and is a social worker by profession, who has earned a Master of Social Work degree. He is accountable to the administrator of the larger service or some division of it, rather than to his own policy-making board.

The center is staffed by approximately three persons, two of whom are considered "professional" workers, with the third being a secretary or clerical worker. There is an average of one professional staff person to every 1,000,000 persons in the population. It is very unlikely that the help of volunteers is used at the center.

The center offers a specilized service, most likely giving information about only mental health services or those for alcoholics, rather than a general service in which information about the entire range of health, recreation, social, and welfare services is given. The agency typically knows of more tan 55 resources to which clients may be referred. It is likely that the center maintains some form of contact with over 50% of the agencies known to it, primarily through telephone calls.

The agency handles between 250 and 749 requests for information per year, or approximately 290 annually per 100,000 population. The major portion of all requests are made by telephone call rather than by personal visit. The persons utilizing the information and referral service are in large part not professional persons, but are members of the general public, asking for themselves rather than other persons. These persons typically are not frequent utilizers of the service system. Center administrators believe that over 60% of all inquiries are satisfactorily handled by simply giving information, guidance, or direction. Follow-up to ascertain whether or not the client actually reached the service to which he was directed is unlikely. Other direct services, such as operating a holiday clearing house or volunteer service, are not likely to be included in the information and referral center's program of activities.

The center is quite likely to gather certain data concerning: client characteristics; how the client contacted the center; what kind of service he requested; and to which agency he was referred. The center is also very likely to communicate relevant aspects of these data to planning bodies within the community, particularly with regard to identifying gaps in the community's service system.

Information concerning the actual operating budget for the average information and referral center is not readily available. Based on very limited knowledge, the annual budget for operating the composite center is in the neighborhood of $25,000. (This is the minimum figure for operating an information and referral service suggested by Lester, Smith, De Paoli, & Braber, 1968, p. 301.)

CHAPTER 5

A Study of Need

This and the following two chapters address themselves to an obvious, but often overlooked, question: what is *need?* It is a basic premise of this report that for an information and referral center to reach maximum potential and effectiveness, it must satisfy some community need that is not being taken care of in other ways. Although the material in these chapters is based primarily on a study of needs as they apply to the elderly, the perceptive reader will readily be able to see the applicability of the ideas to other segments of the population as well.

Defining needs

Identification of need based on current conceptualizations does not adequately permit the development of programs that serve the needs of the elderly. Need, itself, is a relative, subjective concept. Furthermore, there is an intertwined relationship between needs and barriers to services that prevent needs from being met. These barriers can be conceptualized as needs themselves in that, if they are not overcome, they delay action and prevent a primary need from being met.

The two most salient factors associated with an individual's failure to use a service are the perceived availability of the service and adequacy (value) of the assistance provided by a service. Barriers that prevent use of the service by the individual may be intrinsic to the individual, (e.g. lack of knowledge; negative attitudes and beliefs; or physical limitations) or external, but still related to the person (e.g. lack of money; no means of transportation; or poor location). Barriers associated with the service system include inadequacy or lack of services, the attitudes of the service provider, and the methods used to give assistance.

The concept of linking or "matching" people with needs to the services that effectively meet those needs is an often repeated and apparently straightforward objective of community planners, service providers, researchers, evaluators, and policy makers. Among other sources, this has been touched on by Beattie (1968); Fowler and McCalla (1969); Kutner, Fanshel, Togo, and Langer (1956); National Council on the Aging (1964); REAL Service (1969); Sigler (1965, 1967); and the United Community Funds and Councils of America (1961).

On a more abstract level, however, providing services that "meet needs" effectively, or that have some value in providing solutions for the individual, becomes a problem of evaluation and measurement.

> Evaluation is essentially an effort to determine what changes occur as the result of a planned program by comparing actual changes (results) with desired changes (stated goals), and by identifying the degree to which the activity (planned program) is responsible for the change [Trantow, 1970, p. 3].

With reference to the individual, the primary concern is to change a situation to one that is "more desirable." The actual outcome of the efforts must be determined in relation to the planned outcome. Those aspects of the program that prevent achieving the planned goals are of interest, as well as those external factors which may account for less than successful completion of the program.

It is assumed that desirable changes take place to the extent that the program is used by those who need it. To match people in need with the services that meet the needs, there must be an awareness of "three basic determinants of the use of community facilities: community needs, community resources, and disposition to use services [Kutner et al., 1956, p. 184]."

The concept of planning and providing effective programs to meet needs involves identifying both the needs and the characteristics of the users (Blum, 1966; Kutner et al., 1956). This assessment should allow for:

1) The recognition that certain needs do exist, and the identification of their kind and extent.
2) A recognition of alternative actions (programs) that are feasible, appropriate, available, and/or essential. This permits more rational choices among alternatives.
3) Determination of factors that prevent or block the attainment of desirable outcomes, due either to aspects of the program or characteristics of the individual (Kutner et al., 1956; Mathiasen, 1969).
4) Evaluation of the effectiveness of programs intended to meet needs (produce desirable outcomes).
5) Evaluation of actual outcomes or changes.
6) Re-establishing goals and program priorities, which, operationally, results in the modification of existing programs or the creation of new ones.
7) Forecasting changes in the characteristics and needs of the community and the emergence of new needs in the same groups or different sub-groups. Such changes suggest long range plans for the provision and projected utilization of services.

It is obvious that there is a complex, interacting relationship between needs, the existence of services, the use and effectiveness of services, and the decision to plan for meeting needs through providing community services. A central issue involves the value of the program to the "needy" people who use it. The value of the program is assessed by the outcomes of its use. The second issue for gauging the effectiveness of services involves decisions about non-use of the services. Is non-utilization of services an instance of absence of need for the service? Or is non-use an indicator of unmet need and due to some failure in the service program?

It is not really possible to discuss the question of needs without considering the effectiveness of the service system. An evaluation may affect further decisions to continue funding or to recommend modification or termination of the program. It is not the purpose of this paper to deal with these issues, except to point them out. As questions, however, their answers have important implications for individuals with needs and for the planners and providers of community services.

Of equal importance, but more fundamental, is the assumption that when we speak of needs and effective solutions, we know what we mean. This assumption also implies that we can determine when those needs have been met. The intent of this chapter is to clarify and make explicit some of the inadequacies of the current conceptualization of need, and to investigate the literature dealing with factors that prevent needs from being met.

Conceptualization of Need

A major assumption underlying the evaluation of the effectiveness of services is that we do, in fact, know what needs are, and can determine when they have been met. The requirements for this assumption include:

1) Consensus about an explicit, objective definition of need;
2) Agreed upon, specified goals or outcomes for meeting a need; and
3) Objective criteria by which to assess that a need has been met.

The basic question is: do we presently have these essential elements (definition, goals, and criteria) on which to base decisions about the effectiveness of services, and hence, about planning and providing services?

Need as a Dispositional Concept

Before statements about the existence of need can be made, it is essential that we have an operational definition of the concept. That is, a definition which includes specific operations for determining when an instance of the concept exists. The concept of need is unlike concepts whose referents are physical objects. For example, a physical object, such as a table or chair, can be defined by certain observable characteristics or attributes. However, need is an abstract concept and does not have physical attributes to specify it. For example, a dictionary definition of "need" includes these possibilities: "a lack of something requisite, desirable, useful . . . a condition requiring supply or relief . . . want of the means or subsistence";as further qualification, need may imply "urgency and may suggest distress [Webster, 1963]."

Since need cannot always be defined by observable characteristics, we refer to it as a construct. Constructs are unobservable properties or conditions (such as attitudes like happiness, gentleness, or aggressiveness) that are inferred from behavior and other observable events. Need is also a dispositional concept. That is, it refers to the propensity of an individual to "behave in certain ways or exhibit certain behavior under certain conditions [Brodbeck, 1963, p. 49]." However, the behavior that we use as an index of this unobservable condition does not define the need itself.

We can only infer or hypothesize that a behavior or event is a manifestation of some condition, construct, or dispositional concept. For example, the construct "hunger" may be inferred from observation of eating behavior, loss of weight, or an affirmative response to the question, "Are you hungry?" The construct need may also be inferred from many kinds of behavior such as an affirmative response to the question, "Do you need X?"; observation of a request or demand for X; or observations of physical states such as torn and dirty clothes, shelter that is cold, etc.

Operationalizing a Definition of Need

How do we adequately define need if it is an unobservable condition whose existence can only be inferred, rather than physically measured? To be adequate, a definition of need must be able to specify for a large number of people, across time, an instance of the concept. That is, it must be reliable in the sense that many people using the definition will arrive at the same conclusion or inference about the presence or absence of an actual instance of the condition.

To provide a reliable definition of need requires specification of the conditions under which we can observe an instance of it. The qualifying conditions are the antecedents or situations that allow the observation of certain behaviors. The manifestations of the behaviors permit us to infer that a need exists. The entire definition of the concept is stated in the form of a relation between antecedent and consequent conditions, or a statement such as, "if X, then Y." For example, we may define a need for food in terms of this statement: if we ask someone about the number of meals he eats, and he tells us a number that is two or less, then we say he has a "need for food." Under these conditions "asking" is an observable behavior. The reply is also observable. The two observable statements, taken together, define the concept, "need for food," according to the above definition. If we had asked the question about the number of meals, and the reply was that four meals were eaten, this would not be an instance of need, by this definition. In essence, the "if" part of the statement is the index we use for measuring, and the "then" part determines the criterion behavior we must observe, in order for the condition "need for food" to be present.

It is apparent that these definitions are arbitrary. This is inevitable when one attempts to define constructs or dispositional characteristics. However, because the definitions are arbitrary, they can be changed so that they can be made meaningful for the particular context in which they are used. The critical point is that such concepts be recognized as arbitrary, regardless of the situation in which they occur. It is only by recognizing this fact that one can begin to develop a meaningful definition for such abstract concepts as need. Without a meaningful definition, it is impossible to measure the presence of need.

Current Problems Relating to Need

The following points summarize the present status of the concept of need as it is discussed in the literature relevant to the aged population: professionals in various fields may not specify a definition of need at all, operational or otherwise. In the few instances when a definition is provided, the necessary operational conditions for determining an instance of the need are not given. Hence, there is an adherence to private definitions of the concept, which results in considerable confusion in determining when an instance of the need exists, or to what extent it exists. A further problem is that many other terms are used synonomously with need.

Often there is a failure to specify even a subjective definition of need. Although the term need frequently appears in the literature on gerontology, planning, and service provision (American Public Welfare Association, 1961; Dorman, Hoerner, Wilcox, Boydstun, & Lingren, 1968; Gatter, 1962; Gerontological Society, 1968; Goodstein, 1962; Kaplan, 1960; Kaplan & Williams, 1961; Kent & Hirsch, 1969; National Council on the Aging, 1964; Poor, 1969; Richardson, 1964; Sigler, 1965, 1967; U.S. Senate, Special Committee on Aging, 1967, 1969), in only one publication (Hill, 1961) does the author attempt to define the term need. Hill concludes that there are multiple problems in the use of the term, and does not settle on a specific definition. Thus the reader is required to provide his own private definition of the concept, assuming that it is congruent with a particular author's intended meaning.

An examination of the literature also suggests that there are several terms that are used in the same sense as the concept of need. Kretch, Crutchfield and Ballachey (1962) discuss the positive and negative forces that motivate an individual. "Such terms as 'wants,' 'desires,' 'need,' are usually seen as positive forces that impel a person toward certain objects or conditions . . . [p. 62]." Negative driving forces, such as fears and aversions, direct action *away* from objects or goals. These authors use the term "want" to include both of these tendencies. Want in this instance is synonomous with desires, needs, and motives as positive forces, as well as with fears and aversions, as negative forces.

Such phrases as "the problems of the aging" (Loether, 1967), are used in discussing the areas of housing, health, interpersonal behavior, and employment. In this context, the problems of the aging are very similar to the needs of the aging in other contexts. For example, the term "need" can be used interchangeably with "problem" in the following statement without altering the substance or the train of thought: "A problem [need] may be said to exist when someone is motivated toward a goal [Sorenson, 1968, p. 13]." It should also be noted that this is similar to the use of the term want (Kretch et al., 1962) which exists if the individual is directed toward some positive condition,

but is prevented from taking action because "he sees no way" to achieve the goal.

References are also made to the "concerns of the aged" (Governor's Citizens Council on Aging, Minnesota, 1968), which connote the same meaning as problems, needs, wants, and desires. At hearings in which citizens expressed their concerns, they most frequently referred to needs for resources, such as low cost housing, more transportation, more doctors, etc. They also talked of concerns in reference to negative outcomes or conditions to be avoided or removed, such as the high cost of living, taxes, and loneliness.

CHAPTER 6

Ways to Define Need

The confusion which surrounds the use of need could be overcome if each author using the term explicitly states his own definition. This, of course, is likely to bring to the surface the general lack of agreement about the definition of need. The different meanings of the term need are summarized under the following categories: 1) resources, 2) motivational states of the individual, 3) desired goals for the individual, 4) criteria used for assessment of the condition, and 5) combinations of these.

Resource Conceptualization of Need

One conceptualization could be based on the resources that are instrumental in helping an individual obtain a goal. One may consider general classes of resources. The first is comprised of concrete, tangible objects that may be part of the immediate environment. The individual may be able to obtain such resources for himself and thus satisfy his own needs. The need for food, shelter, and income may be thought of in this context. However, even these objects frequently are not adequately specified to permit accurate measurement.

Some references, which are compatible with a resource concept of need, do include a statement of criteria, but are in an indefinite form, requiring subjective evaluation: e.g. moderate, but adequate income; nutritious food; special housing facilities. The criteria of "moderate," "adequate," "nutritious" are not operationally defined, nor are the referents "income" or "food" clearly specified. The goals or outcomes are unstated, but may imply that such resources are instrumental in reaching a goal. For example, the resource "moderate, but adequate income" may function in relation to a variety of goals. It is assumed that the individual can buy his own clothing, or food, or pay for a taxi, etc., provided he has the stated resource.

The second definition of need involving a resource concept can be based on those resources that involve a *process* or *activity*. Some activities or processes are not immediately available in the individual's environment and are not within his control to provide for himself. Examples of such resources include driver training, vocational rehabilitation, retirement counseling, consumer education, health care, etc. Process resources generally may be thought of as enhancing some aspect of the individual's life, such as improving his employment possibilities, satisfaction with retirement, ability to buy wisely, or health status.

Conceptualizations Based on Motivational States

Needs may also be conceptualized as motivational states or attitudes of the individual. They may be specific or general, and, as previously discussed, are constructs. They are unobservable

dispositions that may be inferred from a variety of behaviors. The primary difficulty in specifying motivational states as needs is that we have not developed reliable indicators of these states, nor do we have a definitive list of such states. Since, at this time, there are no suitable operational definitions of these constructs, they are not useful as either measures or criteria of need.

Conceptualizations Based on Attainment of Positive Outcomes

Some statements of need, rather than referring to specific resources or processes, refer to general "desirable" or "ideal" goals for the individual. Examples taken from the Older Americans Act (U.S. Government, 1965) of outcome conceptualization are the "need for the best possible physical and mental health" or the "widest range of opportunity for meaningful activity." Problems develop here when we try to specify what is meant by "best possible" and "widest range." Further, such concepts as "health" and "meaningful activity" are relative concepts. They both imply multiple sub-categories of need (mental health, absence of disease states, etc.), each of which must be operationally defined. There may be many suitable courses of action to meet such needs. For positive outcome concepts of need, the presence of the condition represents an absence of need. To the extent that health is not the "best possible," or the "widest range" of opportunity is not available, a need might be said to exist.

Conceptualization Based on Avoidance of Negative Outcomes

This concept of need is based on the avoidance of a condition that is negative. Rather than actively trying to reach a positive goal such as "best possible health," the goal is to avoid a negative condition. For example, a need may be "a want or necessity so urgent that unless it is supplied death will result [Hill, 1961, p. 65]." Although the need is not specified, it is implied that its presence will have serious consequences. The criterion here is the anticipated negative outcome. This concept implies that a need is met if we do not observe the specified negative outcome. Thus, there is a very large range in which we may say that the need is met. The resources that serve as potential means for avoiding a negative outcome may also be large in number.

A proposal by the National Council on Aging (1964, p. 10) constitutes a variation in this concept of need: A need exists or remains unmet to the extent that there are "personal and environmental factors that are detrimental" to the attainment of positive conditions. This concept implies that there are dual criteria for the assessment of need. The first criterion is the absence of some positive condition. The second criterion involves factors that are causal or related to the maintenance of the negative state. One of the objectives of the Older Americans Act is a good example: "Opportunity for employment with no discriminatory personnel practices because of age." The first portion of this statement refers to a positive condition, and, in this instance, need would exist to the extent that there was an *absence* of "opportunity for employment." A need would also exist when discriminatory practices that prevent attainment of the goal are *present*. Meeting the need depends on the presence of a positive situation as well as the absence of a negative situation.

CHAPTER 7

Barriers to Need Satisfaction

A concept that often appears in the literature related to needs or problems is that of "barriers" or "obstacles" (Barry, 1958; Donahue, 1965; Kalimo, 1969; Mathiasen, 1969; Rosenstock, 1966; Sorenson, 1968; Citizens Committee of United Community Funds and Councils of America, 1968). Generally, these terms are similar to those needs conceptualized as an avoidance of negative outcomes. As discussed by Kalimo (1969) and Rosenstock (1966), barriers are subjectively perceived by the person as factors that make action difficult or inconvenient and, thus, prevent activity that would result in meeting needs. In this same context Sorenson (1968) refers to obstacles as "circumstances, objects or events" hypothesized by the individual, which may or may not exist in fact, but which "keep him from achieving his goal [p. 21]." To the extent that an action or the results of an action are perceived as having negative aspects, a barrier is present. These perceived barriers or obstacles maintain a negative situation (need) by delaying or preventing action until they are overcome.

Barriers that arise in the process of meeting needs become needs themselves. They are sub-needs that must be met in order to satisfy the primary need. For example, an initial need may be to receive health care. However, the person may not have enough money to pay the doctor. In this case, the need for money is a barrier or sub-need that may remain unmet and prevent action toward the final goal of receiving health care. In this context, barriers are similar to negative forces (Kretch et al., 1962); fears or anxiety (Pomeroy, Lejeune, & Podell, 1969; Sorenson, 1968); or circumstances which motivate the individual away from a goal or condition (Kisch, Kovner, Harris, Browne, & Harris, 1969; Moles, 1969; Morgan, David, Cohen, & Brazer, 1962; Ornati, Whittaker, & Solomon, 1969; Storey, 1962). They are problems that the person sees no way around (Sorenson, 1968).

Barriers Related to the Service System

Barriers may also be factors in the service system which prevent utilization of the system (Barry, 1958; Hall & Mathiasen, 1968; Mathiasen, 1969; Moles, 1969; Citizens Committee of United Community Funds and Councils of America, 1968). While the barriers discussed in the preceding paragraph refer to psycho-social or physical characteristics of the individual, these barriers reside not in the individual, but in the service system itself. Such barriers may be lack of manpower (Hiestand, 1966; Purola, Kalimo, Sievers, & Nyman, 1968; Tibbitts, 1969); negative characteristics of the staff (Krauss, 1963; Leeds, 1962; Mathiasen, 1969; Spence, Feigenbaum, Fitzgerald, & Roth, 1968); inconvenient architectural features (Andrews, 1963; National Commission on Health Services, 1967a; Tibbits, 1962); or factors associated with location that reduce accessibility of the service (McCann, 1967; National Commission on Health Services, 1967b; Ornati et al., 1969).

Barriers may also appear within the planning body which is responsible for the structure of the service system. Hall and Mathiasen (1968) discuss such factors as an inefficient administrative structure; poor community organization; lack of communication between agencies; and poorly specified legal responsibility. Other barriers related to the planning function center about financing, sporadic programming, political decision making, and the nature of the problems and community recognition of them (Barry, 1968; Blum, 1966; Conant, 1967; Kaufman, 1966; Mathiasen, 1969; National Commission on Community Health Services, 1967b, 1967c; Wilson, 1967).

We can, say, therefore, that there are two general classes of barriers related to obtaining services: the first centers around the limitations of the individual himself; the second is associated with flaws in the service delivery system. Both classes are examined in detail in the following sections of this chapter.

Barriers Relating to the Individual's Use of Services

Before the individual attempts action to meet his needs, he must determine the availability and adequacy of the service resources. In terms of his own perception of his problem, resources may not

be adequate for meeting his need. This perception is likely to be a subjective assessment of the situation. He may determine that resources are not available because:

1) He does not know about them.
2) He does not perceive known resources as relevant for use in his specific situation (e.g. they are not related to his goals).
3) His perception of known, available resources is negative.

As several authors have indicated (James, 1967; Kent & Hirsch, 1969; Lipman, 1965), the individual may have certain resources that enable him to cope with problems or facilitate the use of other problem solving agents in the environment. Such resources as education, health, and employment status are factors that may be instrumental for an individual to meet a need. When the individual lacks such assets, barriers to independent problem solving may arise. Barriers related to the individual fall into two basic areas: one is essentially internal and may be called an "intrinsic barrier." The second is external to the individual, and may be called an "extrinsic barrier."

Intrinsic Barriers

Intrinsic barriers may or may not be perceived by the individual. However, they are unique to each individual and result from his interpretation of his environment. Some examples:

1) Lack of knowledge involves such factors as total absence of information and inaccuracy of information.
2) Lack of symbolic or cognitive skills restrict the individual's ability to receive, process, and hence, communicate the information that may be available to him.
3) Negative attitudes may render adequate knowledge useless. For example, the individual may know the seven danger signals of cancer, and have accurately identified the presence of one or more of these signs; he may also know that Medicare will cover the expense of treatment, etc., but he may have a negative attitude about doctors, or going to the doctor for a "trivial reason," and thus, not act on the basis of his knowledge.

Extrinsic Barriers

Extrinsic barriers are essentially external to the individual. They reduce his effectiveness or his ability to act. Some examples:

1) Insufficient money.
2) Inadequate transportation or poor location in relation to desired services.
3) Inaccessability to special privileges: Social Security, food stamps, low cost housing, retirement programs, credit buying, or bank loans.

Barriers Related to Social Agents Providing Services

There are a variety of social agents that may either assist the individual in the process of meeting his needs, or actually provide resources to supplement those of the individual. Social agents may be more personal, familiar, or immediate sources of assistance, such as friends, spouse, children, and neighbors. Or social agents may be persons charged by society to administer various programs approved and supported by the society (e.g. doctors, social workers, or Public Health nurse). The unavailability or ineffectiveness of these social agents may result in the failure to identify and alleviate need.

In general, there are two classes of barriers. They may be associated with social agents. The first involves those characteristics of the social agent which influence his assessment of the individual's needs. Such barriers generally are the result of a negative disposition to provide assistance to the individual. The second class of barriers concerns the method and manner of providing assistance.

CHAPTER 8

The Planning of Human Services: A Brief Description

Data from a planning support function of an information and referral center can influence the planning of human services. The components of the planning process and the potential impact of data upon them are briefly discussed in this section. However, lack of data is not the only factor which hinders planning. Therefore, the potential impact of providing improved data for planning should not be overestimated. Some of these other factors which limit the planning process are also discussed in this chapter.

Impact of Data Upon Planning Organizations

The impact of improved or new data should be felt in all aspects of the planning process and at each level of planning: local, regional, state, and national. Most planning processes have four major components: research, planning, implementation, and evaluation. The potential impact of data on each of these is briefly discussed below.

Research

Research is the source of the basic data used in planning. As such, it can be considered the foundation of the planning process. Zimbalist (1964) states that:

> the role of research is to provide verifiable data, ranging from simple fact-finding to major surveys and studies of community needs and services, that will strengthen and underpin local planning and action [p. 13].

The planning support function of information and referral centers can provide verifiable data to external planning organizations.

In many instances, planning organizations do not have the basic data needed to make decisions about present or future programs. Through a planning support function, information and referral centers can contribute to the base of knowledge about a population which is necessary to assess their needs accurately.

Planning

Once conclusions about human needs have been reached, the planning process, as distinct from research, begins. Through the application of appropriate statistical techniques such as forecasting, prediction, correlation analysis, and regression analysis, planning attempts to determine the nature and cause of problems. The results of such efforts are helpful in determining feasible goals and in developing programs for solving health and social welfare problems in both the short and long run. Gordon Manser (1960) describes the planning process as:

> the definition and measurement of major health and welfare problems, the understanding of causative factors, the establishment of goals based upon needs and existing resources, and the development of a constructive program of community services to move toward these goals [p. 35].

Reliable and relevant data, analyzed by appropriate statistical techniques, can contribute to the documentation of those factors which contribute to the needs of a target group. Such information is useful for setting goals and developing realistic and effective programs to meet these needs.

Implementation

Implementation refers to acceptance by decision-makers of the plans developed by the planning process and the operation of these programs. The use of data by external planning organizations in the implementation of programs is at best subtle, as the decision making process is frequently

political in nature. Data can be used in public relations to inform the public of the severity of a particular situation, thus influencing public opinion and bringing to bear pressure on the decision-makers responsible for implementing plans. Relatively little objective knowledge exists in this area.

Evaluation

After implementation and operation of a program, the next logical step for a planning organization is to evaluate specific aspects of the program, such as:

1) Program outcome.
2) Program processes.
3) Program efficiency (as compared to alternative programs).

Data that can monitor changes over specific time periods are needed in order to determine how well the plan, as implemented and operated, is reaching its goals (Cronbach, 1963). When data are not available, this task becomes subjective and is often unreliable. Because evaluation requires specific change data, these requirements should be considered well before the plan is implemented and operated. Such data are often impossible to collect after the program has started.

Deterrents to Improved Planning

Because planning and implementation are complex processes, there are many deterrents to achieving the best possible results. For example:

> Seldom is information wholly adequate; explicit specification of goals is often lacking; only a few alternative sets of means and ends can usually be considered; the ability to predict all possible consequences is highly restricted; meaningful evaluation for optimizing is difficult; and prior decisions often serve as constraints on the decision at hand [Bolan, 1969, p. 302].

A modest study of two local health and welfare councils, a metropolitan planning organization, a state planning agency, and a review of the literature on community planning, indicate that the following broad categories of problems impede the improvement of the planning and implementation process at all levels:

- Data limitations
- Staff limitations
- Institutional rigidities
- Leadership limitations in decision making
- Community priorities
- Tension between the planning and decision making processes

Data Limitations

The lack of data specifically collected to support planning is a common problem at all levels. As long as this situation exists, many planners must continue to make plans based upon subjective information. Many times data exist but are not amenable to statistical or mathematical treatment. Because of this, the use of data in planning is either superficial or excluded altogether. Instead, the method of *concensus by experts in the field* is often employed.

Staff Limitations

The skill of planners varies greatly. These variations are found vertically from local planning agencies on up through the Federal level; they also occur horizontally across particular levels of planning. Educational backgrounds may include social work, economics, sociology, political science, public health administration, physical planning, as well as other areas. Wide variations are also found in the previous work experiences of planners.

Given the educational backgrounds and previous work experience of planners, the use of data in planning varies considerably. Typically, the rational planner is thought of as using decision models and appropriate statistical techniques in order to determine goals and alternative solutions or methods for reaching these goals. This does not, however, mean that a person must be a degreed planner, statistician, or mathematician to use a rational approach. On the other hand, it does mean that a rational approach requires sufficient knowledge to be able to use all available and relevant data to the fullest capacity to support the planning process. Perloff (1965) states that, "planning personnel within councils often need updating on modern planning techniques, such as those involving the use of computers, and new programming and budgeting methods [p. 298]." Although this remark is directed at the local level of the health and welfare council, there is no reason to believe that it does not apply as well to regional, state, and Federal levels.

Institutional Rigidities

A critical point of tension between the planning process of health and welfare councils and the decision-making process is the institutional rigidity of the budgeting process. Becker (1968) states that:

> Our judgment consists largely of across-the-board percentage increases for agencies from year to year – the so-called "add on" budgeting technique. . . .
>
> While this type of across-the-board percentage increase budgeting is relatively simple, it eliminates one of the primary roles that private welfare agencies should be fulfilling in the community – that of innovation, experimentation and adaptation. Since, under this system, it is patently out of the question for an agency to expect substantial budget increases or significant supplemental funding for special projects, the agencies simply do not propose such projects or any innovations. This makes the job of the planning and priorities people somewhat easier, but it is destructive, in the long run, of agency initiative and morale. It also leads to very pertinent criticism of the Fund and its agencies as being rigid and inflexible [p. 10].

These institutional rigidities at the local level are in part due to the leadership problems in the decision-making process.

Leadership Limitations in Decision-Making

Morris and Randall (1965) state that leadership at the local level is not representative of the community at large. Instead, socially influential individuals, economically influential persons, and a scattering of representatives of civil organizations make up the decision making bodies to the exclusion of minority groups and representatives of special concern groups such as the aging. They go on to say that:

> Data are not yet sufficiently complete to permit final conclusions, but in a preliminary way it is evident that the present leadership of health and welfare planning associations in urban communities is confronted with great difficulty in accommodating to the demands of rapid change, especially as they affect the *reallocation of limited resources* they control. The concepts, attitudes, and values of the central decision-makers are so focused on a balanced view about community affairs that rapid change appears to be uncongenial. As a result, their organizations seem to perform the valuable function of maintaining stability among established programs. One consequence is, however, that special interest groups – *those concerned with the needs of the aging* – must function outside as well as inside these planning associations in order to influence welfare services by their independent pressure, or they concentrate their actions on the creation of new programs rather than on changing old ones [emphasis added, p. 99].

Community Priorities

Community priorities and values have a tremendous effect on the ability of planners to have their plans implemented. The best data possible will have little or no effect, even assuming an optimal plan, if the community and its decision-makers do not give a high priority to the goals of the plan. When the recommendations resulting from the planning process conflict with those of the decision-making bodies, leadership will probably decide in favor of the existing institutions, even though these institutions may have little relevance to the general needs of the community.

Tension Between the Planning and Decision Making Processes

The tension between planners and decision-makers was suggested previously as a major reason for the ineffectiveness of planners to solve social problems. The literature suggests that particular characteristics of plans may be unacceptable to decision-makers. Bolan (1967) lists five characteristics of plans that influence its chances of success in being accepted by the decision making body. These characteristics are:

1) *Ideological content* – If the plan can be argued against on ideological grounds, the plan, however, rational, will be unacceptable.
2) *Scope of the proposal* – The greater the number of people directly affected by a plan, the harder it is to reach a decision.
3) *Time horizon and flexibility* – Easily modified plans seem to be more acceptable to decision-makers than plans which are of long duration and inflexible.
4) *Complexity of organization needed to carry out plans* – If cooperation with other agencies is necessary to carry out the plan, and this cooperation threatens the political environment of the cooperating agencies, then the plan will probably not be accepted.
5) *Confidence in outcome* – Decision-makers are basically conservative, and plans with highly uncertain outcomes will have little chance of being implemented.

These characteristics suggest that a successful plan would have little or no ideological conflict; affect few people; be short in duration and flexible; require a simple organizational structure for implementation; and will have a high degree of certainty of outcomes. To the extent a plan does not conform to these criteria, implementation probably will not be achieved.

Other factors that affect decision-making involve the environment of the decision-making body and its characteristics. Examples include:

1) *Source of power* – Appointed groups of decision-makers whose accountability is rather obscure feel less threatened than their elected counterparts and may therefore take more positive action on planning proposals (Pfiffner and Presthus, 1967).
2) *Formal legal structure* – Highly focused and centralized decision-makers are more likely to produce action on any particular proposal than a decentralized decision structure (Dahl, 1959).
3) *Relationship of the planning body to the decision-making body* – A planning body attached to the power center will be more effective than independent or advisory planning bodies (Banfield, 1961).

Additional hypotheses about factors which influence the decision-making process can be found in Bolan's (1969) discussion of community decision behavior.

CHAPTER 9

Information and Referral Center Activities for Collecting and Distributing Data

Planning for human services is often hampered by the lack of timely and accurate data about the needs of people and the resources and services available to meet these needs. Information and referral centers have the potential to provide much of this data. Through the use of their resource files, their contacts with clients, and their outreach efforts, information and referral centers can provide data on available resources; the specific needs and characteristics of their clients; and the needs of the population in the community at large. Many information and referral centers already collect and distribute such data to planning organizations.

While the actual planning of human service programs takes place in organizations which are external to the information and referral centers, the information and referral center can influence this planning through the collection and distribution of data.

Data Collection

Data collected as part of a planning support function of information and referral centers fall into four broad categories:

Resource Information

The basic tool of any information and referral center is a resource file. These files contain information about services rendered by public and private agencies operating within particular geographic areas, fields of service, agency characteristics, eligibility requirements, and so forth.

Service Information

Information on the services provided by the information and referral center can be kept by documenting such variables as: total calls and/or visits, referrals by agency or problem area, and total requests for help for which there are no services.

Client Information (information about information and referral center clients)

When individual case records are kept, variables such as age, sex, income, census tract, housing, transportation, and recreation needs can be made available for use by planners.

Survey Information

In some cases, depending upon how the information and referral center perceives its purpose, community surveys may be conducted to give the center information about the needs of individuals in the community. Such surveys would provide planners with information about the needs of those who do not use the information and referral center.

Activities Needed to Collect Data

To collect the data described above, an information and referral center must record and document specific facts. In terms of the planning support function, the data collection must be a definite and explicit activity undertaken for the express purpose of providing planning organizations with knowledge about the target population. To provide this information, centers would have to undertake the following:

Resource Information

A thorough investigation of all agencies rendering health and social welfare services, for the center's geographic area, would have to be undertaken. This task can take about six months depending upon the size of the area and the number of staff involved. In order to keep the information in the resource files relevant, a continual up-dating procedure must be followed.

Service Information

To record the services provided, data should be gathered on the kind of contact, the service requested, and the kind of service rendered.

Client Information

A uniform intake sheet must be filled out of each client. Included in the record are demographic variables, location variables, service information, historical information, and possibly attitudinal data.

Survey Information

Surveys of the target group may be undertaken as part of an outreach activity. The kinds of questions included would be similar to those answered through the service and client information records discussed above.

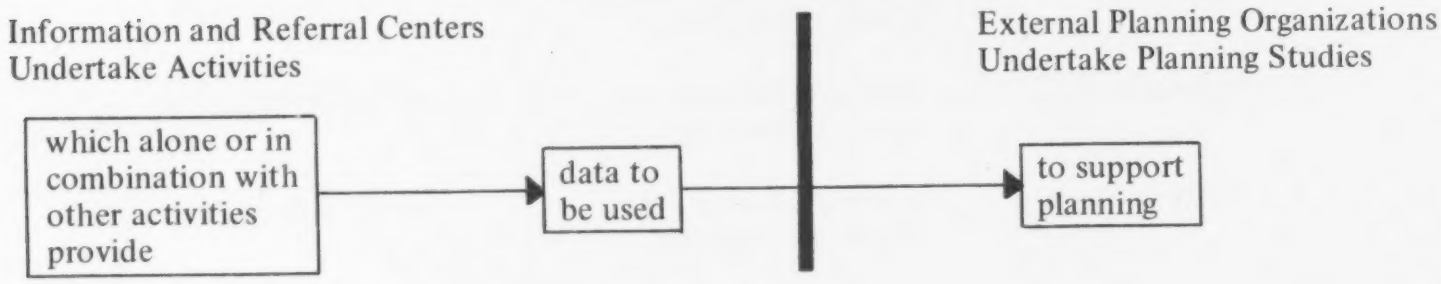
Center Activities and the Planning Support Function

It is expected that centers will differ in their actual activities, due to differing community needs. Each activity can generate data useful both for planning and for the center itself. For example, resource files will be used by the originating center to make referrals and follow-ups, while planners may use aggregated resource information to determine the current community capacity for services.

The extent to which a specific information and referral center can support planning may be determined by the following sequence. First, identify the activities which the information and referral center undertakes. Second, identify the kinds of data these activities can provide or generate. Third, identify the kind of planning studies which require the particular data the activities can provide. This sequence is shown schematically in Figure 1. Following this sequence of identifications permits the determination for each information and referral center of its potential to support planning.

Information and referral centers must undertake certain activities and thus have certain data in order to fulfill their basic functions. The centers may also carry out optional activities which can provide additional information. But this additional information is not necessary to carry out its basic function.

FIGURE 1
RELATIONSHIP OF INFORMATION AND REFERRAL CENTER ACTIVITIES
TO THE PLANNING ACTIVITIES OF OTHER ORGANIZATIONS


Information and Referral Centers
Undertake Activities
which alone or in combination with other activities provide
data to be used
External Planning Organizations
Undertake Planning Studies
to support planning

The basic activities of centers will vary from center to center. Some of the possible activities an information and referral center can carry out are the following:

1) Provide *information.*
2) Steer and/or *refer.*
3) *Follow-up* on referral.
4) Diagnose/treat/*counsel.*
5) *Advocate* on behalf of a client.
6) Seek to *influence* program policies of agencies and/or the delivery of services.
7) Perform an *outreach* function to recruit clients and/or for research.
8) Monitor/*analyze*/report the existence of the *needs* of the elderly and effectiveness of information and referral centers.
9) Perform *public relations* in the form of reports and advertising.
10) Provide *direct services* other than information and referral.

Variations in the types and quality of the activities will occur, depending upon the experience and background of the center's staff and the community environment. These variations in types and quality will, in turn, be reflected in the quantity and quality of the data that can be provided.

The relationships between activities and data needed to support these activities are shown in Table 1. The center column of Table 1 shows the data required to support the activity in the left hand column. The right hand column shows optional data that centers may collect at the same time, but which would not be necessary in order to fulfill the basic activity.

TABLE 1

REQUIRED AND OPTIONAL DATA COLLECTED BY INFORMATION AND REFERRAL CENTERS

Basic Activities	Required Data[a]	Optional Data
1. Information	Resource information	Service information Client information
2. Referral	Resource information Client information	Service information
3. Follow-up	Client information	Service information
4. Counseling	Client information	Service information
5. Advocacy	Resource information Client information	
6. Influence	Resource information Service information Client information	Survey information
7. Outreach	Resource information Client information	Service information
8. Analyze needs	Service information Client information	Survey information

9. Public relations	Service information	Client information Survey information
10. Direct services	Resource information	Service information Client information Survey information

[a]These data are required for the information and referral service to provide the best service. Without the availability of these data, the quality of the service may be impaired.

The kinds of planning studies that can be supported by the data collected are shown in Table 2. External planning organizations can also use data from information and referral centers in conjunction with other data sources – e.g. census data, surveys from such agencies as city planning, housing and redevelopment authorities, county welfare offices, and health bureaus – in order to improve their planning activities.

Following the sequence of linking activities to the data generated by these activities and to planning studies using this data, the potential planning support function of any proposed information and referral center can be determined. Expanded versions of Tables 1 and 2 and the previously listed ten possible activities would be used in this process.

TABLE 2

EXAMPLES OF PLANNING STUDIES THAT COULD BE SUPPORTED BY DATA FROM INFORMATION AND REFERRAL CENTERS

Data	Planning Study
Resource information (Resource files)	1. Categorization of programs by type and/or fields of service for use in community priority studies.
	2. Studies showing the geographic distribution of services in relation to known populations of elderly people.
	3. The development of studies to determine service capacities and how they relate to gaps in service and barriers to service.
	4. Eligibility studies and their relationship to barriers to service.
	5. Decentralization studies showing the patterns of expansion by existing agencies.

Data	Planning Study
Service information	1. Studies about clientele that show types of services requested; geographical locations; demographic characteristics such as age, sex, income, race, religion distributions, percentages, and ratios; and referral distributions. 2. Studies using periodic data, trends in client intake, services requested, and identification of increasing or decreasing trends in the above, along with gathering data on referrals, seasonal variations, and other changes in the needs of the elderly, as monitored by information and referral centers. 3. Studies to develop forecasting models to predict case loads. Data may be useful to substantiate the need for more center staff and/or income. Some preliminary correlations may show that specific seasons of the year will show increased demand for certain kinds of services. Other types of time studies or trend analysis may be done with service information.
Client information **(Note: All studies listed under "service information" can also be done with "client information." In addition, more specific studies can be done.)**	1. Studies of the frequency distribution of two or more variables at one time. An example of this would be the study of intake requests by age distribution, sex, income, and/or geographic location. 2. Studies of independence might allow planners to state that particular attitudes, intake requests, or the like are either dependent or independent of individuals' income, wealth, or other factors. 3. Correlation and regression studies may be used to show how client characteristics relate to one another and to predict certain events based upon those characteristics. 4. Studies based on client information collected over time will allow planners to more accurately forecast such things as needs, client characteristics, and needed expansion of the delivery system to handle client needs.

Data	Planning Study
Survey information	1. Studies of particular problems such as housing, income, health, attitudes, and other specific needs.
(Note: All studies listed under "service information" and "client information" can also be completed based on "survey information." In addition, survey information may be used in the adjacent kinds of studies.)	2. Studies to determine if the information and referral center clientele is representative of the total population in the community.

Data Distribution

The first component of a planning support function is data collection as has been described. The second component is the distribution of data to planning organizations at the local, regional, state, and national levels. Information and referral centers may be able to influence planners and policy makers at all levels by providing reliable information for planning and decision making. At the local level, health and welfare councils, United Funds, areawide hospital planning boards, and/or county welfare departments will be making decisions about present and future services. At the regional, state, and national levels, service and policy decisions are also made concerning the delivery of service. The distribution of data to these planning organizations and policy makers may influence the quality of their plans and decisions.

Summary

Many planning endeavors are hampered by a lack of accurate, timely data. Subjective judgement alone often has to be used to develop plans. Information and referral centers have the potential to provide a planning support function, that is, to provide data explicitly for use in the planning process. There are two responsibilities in a planning support function: data collection and data distribution. Information and referral centers have the potential for collecting data on existing services in the community, services provided by the information and referral center, and the clients served by the center. This information can be distributed to planning organizations and decision-makers at the local, regional, state, and national levels.

The role of information and referral centers does not include direct involvement in the planning or decision-making process. Its role is to influence these processes by providing a key element: data and information about the needs and problems of the people they serve.

CHAPTER 10

Uses for the Information and Referral Center Data from a Planning Support Function

Commitment to the concept of a planning support function by information and referral centers has varying implications at all levels of concern.

Individual Information and Referral Centers

Centers may use the data in the following ways: first the centers may study their own referral patterns. Are a few agencies receiving a majority of the referrals when there are other agencies available and equally qualified? Second, the centers may study trends in service, such as intake requests and other indicators of change, which the center staff should be aware of. Third, data from follow-up contact may point to barriers in obtaining services or to gaps in the service system. Last, individual centers may evaluate their effectiveness in linking persons to services. Program emphasis and/or resources might be shifted to assure greater effectiveness in linking clients to the proper services. This constitutes a limited, in-agency, planning function. These uses of data are obvious, but essential, to ensure the quality of service of the information and referral center.

Community Planning at the Local Level (External Planning Organizations)

Periodic data from information and referral centers may establish a base of information about the target population within a community. This information may be supplemented with data from other surveys. In cases where local planners have comparable information about other populations, data about a specific group can add to the total data base and permit a program to be considered on an equal basis with other programs competing for funds. In cases where local planners do not have timely data about other populations, data about a specific segment may provide an incentive for other agencies to submit comparable data to ensure that their programs are considered on the same basis as the programs for the target group, thereby upgrading the quality of all plans.

To the extent that planners at the local level receive hard data on a scheduled basis, they are encouraged to use appropriate planning techniques. By developing excellent plans based upon hard data and sound planning techniques, the planner and his organization are in a stronger position to influence the decision-making process.

Regional and State Level Planning Agencies

At the regional and state levels, aggregate, uniformly collected and coded data allow planning organizations to have an overview of the various populations in their areas. Information on services, needs, barriers to entry, and gaps in service contribute the hard data needed for use in decision models for allocation decisions. Metropolitan-nonmetropolitan, city, county, and small area comparisons indicate mobility patterns, unique problem areas, and trends. At the state level, planning and decision-making may be less complex than at the local level. At the local level, planners and decision-makers must handle a broad spectrum of health and social welfare needs. At the state level, a governor's council or special commission may consider only broad programs for special target groups.

Summary

The planning support function is a concept that provides a rationale for data collection by information and referral centers. The basic assumption is that planning is a worthwhile endeavor and, as such, data should be collected specifically to support it.

Information and referral centers have the potential to support planning by committing themselves to a planning support function. Data collection which is part of a planning support

function is not new to most existing centers which now collect data for administrative, budgeting, and accountability purposes. The planning support function recommends that data be collected uniformly and distributed to external planning organizations. These data could influence planners at all levels of responsibility. The degree of influence these data will have depends upon other factors within the planning and decision-making processes.

Data from a planning support function by information and referral centers have a potentially wide range of use, from the individual centers up through and including Federal-level agencies. As data move upward, they should provide both an overall picture of the conditions of the nation's various needy populations and a picture of the resources available to meet their needs. This should facilitate comparisons within and between areas, so that the total planning process from the local level through the national level is improved.

CHAPTER 11

The Case for a Network of Information and Referral Centers

There appear to be significant failures of the existing community service systems to furnish available services to many individuals who are in need of services. The reasons for system failures to link individuals with needed and available services (which have been termed "barriers to service") are in general multiple and complex. There is clearly no single straightforward step the service system can take to effectively link all in need with available services. Rather, a complex and comprehensive program will be required which in practical terms could significantly improve the situation but probably not alleviate it entirely.

Existing systems for planning services have significant weaknesses. More specifically, current approaches to planning community services place heavy emphasis on the demand for services. These demands are usually made through traditional service channels. This practice results in an uneven distribution of service availability, and may discriminate against those with real needs, who for one reason or another are not skillful in making their demands known.

The delivery of services has also tended to be based on system responses to the demand for services. Surprisingly little research has been done on the degree to which individuals who are not demanding service in fact do need or could benefit from service. Similarly, little research has been done and little is known about how this "residual" need could be effectively served. Since existing planning processes rely on demand data and "political processes" rather than comprehensive and objective data on needs, the simple furnishing of such data would find the planning processes not structured to receive and effectively use such data. Thus, achieving the potential of improving service systems through objective planning of services, which makes use of "needs data," will require a revision of the planning process itself. Such change and improvement must be evolutionary in nature. Analysis of the value of existing information and referral centers supports the contention that some information and referral centers are, in fact, making a contribution to linking individuals with services, and that this general mechanism has a significant potential contribution to make to this problem.

The real impact of existing information and referral centers is complex and not fully understood by any means. There is an illustration in the Appendix which suggests that what may appear to be a real service to individuals may, in fact, not be so in all cases. It is also clear that the value that some of the contacts centers have with individuals may transcend the mere satisfaction of immediate need. These contacts may also serve to familiarize the individual with the service system, so that in

the future he is better able to deal with it himself without further help on the part of the information and referral center.

The state of the art of "information and referral technology" is embryonic and much of what is currently done, is done from a sense of conviction of merit, rather than from a demonstration or proof of that merit. Further, the best means for performing various functions related to information and referral are not uniform in their degree of development. Many activities and functions which could be of potential merit are either not developed, or are under-developed (e.g. outreach). Other activities are relatively highly developed (e.g. resource file construction).

There seems to be a growing belief that information and referral is a "good thing." Along with this movement, there appears to be the development of a "folklore of information and referral technology" among some practitioners and sponsors of existing centers. This has both advantages and disadvantages. It does communicate to others the know-how accumulated by those with experience. But, since little of this know-how has received rigorous evaluation, it offers the significant danger of furnishing the appearance of comprehensive knowledge and thus "locking-in" future systems to a mode which is, in significant ways, unproven. This can prevent the openmindedness, innovation, and the comprehensive search for truth and development that are needed if the potential of information and referral centers is to be achieved.

The degree to which needy individuals are effectively linked to services will vary from community to community, as will the availability and nature of already existing information and referral services. Also, the degree of services available will differ in various communities. Various forms and configurations of information and referral services are in existence and most have some merit in relation to the objective of linking people with services. The concept of "one best way" seems to be inappropriate in the absolute. The concept of a network of services tailor-made to a community offers a meaningful approach. Evidence indicates that at present the best information and referral service may be provided when the center is either free-standing or associated with an organization dedicated to serving a specific group.

There is an inherent danger in any service system which is engaged in what appear to be worthwhile activities, if those operating the system come to feel that these activities are in themselves justified, without a rigorous examination of the real nature of the public service provided. This is an especially great hazard in the case where it has not been thoroughly proven to be of value on the basis of scientific data.

The need for and the ability of local communities to invest in the development of information and referral centers will vary. In order to attain the potential of information and referral centers to link people to services and to contribute to the planning processes, a network, organized at the national, state, and local levels, must be established to provide the necessary leadership and to supply a vehicle for the communication of data, information, and know-how.

The purposes of a network of information and referral centers may be seen as summarized below:

1) To increase the likelihood that a person needing a specific health, welfare, social, or recreational service actually receives that service. This goal can be accomplished in one or more of the following ways:
   a. Provision of information about the services available that are appropriate for the individual's problem.
   b. Referral or steering of the individual to the appropriate resource.
   c. Follow-up to insure that thy individual actually contacted the resource and was satisfied with the service that he received.

2) To identify those persons not utilizing the service system, and to assess their need to use it. In the event that they are in need of certain aspects of the service system, to increase the likelihood that they receive the services by providing information, referral, and follow-up. The following procedures may be used:
   a. Identification of the entire target population, through examination of census statistics and/or survey techniques.
   b. Determination of those members of the population who currently are using the various components of the service system.

c. Determination, by means of personal contact, of those members of the population who are not using the service system, but who have need of it.

3) To make the target population more knowledgeable, so that they are better able to recognize and identify their own personal needs and problems, and the potential use the service system may have for them as individuals. This may be accomplished by:
   a. Directed publicity through the mass media about certain areas known to be problematic for this population, such as housing, dental care, and transportation. The content of such publicity would be specific and changing, depending on the local situation.
   b. Systematic outreach efforts, in which members of the target population are contacted in person or by telephone and informed about various programs for which they may be eligible.
4) To assess the gaps in the service system and the barriers to receiving services by:
   a. Recording requests for help which could not be satisfied by utilization of the existing service system.
   b. Surveying the target population to learn about unmet needs and the desire for services that would be of use to the population.
5) To prepare information from the data obtained in performing the above functions and activities so that they may be used by various planning bodies to improve that portion of the service delivery system that is relevant to this population. This may be accomplished by:
   a. Systematic recording of certain events on standardized forms.
   b. Tabulation of data on these forms.
   c. Statistical analysis of the data.
   d. Interpretation of the data.
6) To influence policy at the regional and state level regarding the provision of services. This may be accomplished by:
   a. The communication of data and information to existing regional and state bodies for the purpose of analysis.
   b. The establishment of regional or state offices whose function would be to collect data from the local information and referral centers, and then to perform the tabulation, analysis, and interpretation of the data.
7) To influence policy at the national level regarding the provision of services. This may be accomplished by:
   a. Establishing a department at the Federal level whose function would be analogous to that of the state offices suggested under 6b, above.
   b. Or by contracting a private organization to perform this function.
8) To evaluate all components of the network on a routine basis, so that programs are, in fact, effective in relation to their objectives. An effective network must be responsive to the changing needs and demands of a population across time: it, thus, must be sufficiently flexible to respond appropriately to these changes. This is to be accomplished by:
   a. Specifying goals for each aspect of the program before the program is implemented. Time constraints must be set with regard to the goals. The context of the evaluation must be to facilitate improvement, not to punish for difficulties or failures. Results of the evaluations should be made public, so that members of the network may profit from the experiences of each other.
   b. An ongoing evaluation at each level of organization, beginning with the local centers.

APPENDIX

An Example of the Problem of Inferring the Effectiveness of Existing Information and Referral Centers from Activity Reports

Unfortunately, the history of human service delivery systems contains examples of services which have been created and offered to the public which were felt at the time to represent a valuable contribution to the public. The passage of time has shown that some of these services failed to provide the contribution that their sponsors and participants offered with conviction at the time. The Social Service Exchange discussed in Chapter 2 of this report is an example of such a phenomenon. While we feel that information and referral services can and, in many existing forms, do offer needed and useful services to the elderly, it is also clear that definitive information proving the value of information and referral centers and the extent of that value has yet to be obtained. It is important, therefore, that further research in this area be conducted and also that policy makers concerned with committing public resources to information and referral services realize the uncertainty inherent in knowing exactly the value of the service being offered by service systems that might be established at this time. They should be aware that there is real evidence that information and referral services are of significant value to at least some of the population for whom these services are furnished, but the real value and magnitude of impact for existing services and potential services has yet to be defined.

The newspaper article included in this Appendix is intended to show how the activity records of existing information and referral centers and testimonies by officials employed by or connected with them can convey a misleading image of the value of such services. We have no specific information on the quality of the service provided by the specific information and referral center referenced in the article nor their interpretation of the incident as far as their services were concerned. However one can easily imagine such an incident occurring in which an information and referral center would receive a call; in response to that, furnish the name of one or two agencies and then record in their files, first, that their service was used, thus inferring a demonstration of the need for their service, and second, that they had, in fact, provided service. Unfortunately, in the case described in the newspaper article, the information and referral center provided nothing of direct value to the client with a problem.

THE MINNEAPOLIS STAR

TUESDAY, FEBRUARY 17, 1970 XCII No. 72 1C

Barbara Flanagan

I'LL LET THE Rev. Richard Keene Smith tell his own story, as he did to his parishioners at Saint Patrick's Episcopal Church in Bloomington.

Read it and then wonder whatever happened to charity — Christian or any other kind.

Father Smith said:

"Don't be an Indian girl abandoned in Bloomington. This week your rector was in the Bloomington court on a matter concerning one of our parishioners. While there, he met and befriended an Indian woman who had been brought in on a misdemeanor charge (itself rather pitiable) and was able to help get her sentence of five days in the Work House remitted with the understanding that he would get her transportation back to Chicago ($12), and a pair of boots ($7). He decided to seek this aid through 'official' agencies to see what would happen:

"(1) He called the Minnesota Council of Churches and was referred to their Department of Indian Work.

"(2) He called the Department of Indian Work and was told they didn't do that kind of help — their work was coordination work. Suggested that he call the American Indian Center.

"(3) Called the American Indian Center (also known as the Indian Citizens' Community Center). Told they could not help, but suggested that he call either of the next two agencies.

"(4) Called the American Indian Movement (AIM) and was referred to the Indian Citizens' Community Center.

"(5) Called the Travelers' Aid and was referred to the Relief Office of Bloomington.

"(6) Called the Relief Office — they were completely baffled. Suggested he call the 'Port' (an adjunct of Portland Av. Methodist Church) or the Bureau of Indian Affairs. (BIA).

"(7) Called the BIA and referred to the Upper Midwest Indian Center.

"(8) Called the Upper Midwest Indian Center, who were the first ones even to recognize that there was a *person* involved. They said they could possibly help, but were reluctant to do so. They referred him to the Catholic Welfare Services.

"(9) Called the Catholic Welfare Services and again given 'humane' answers. Was told they would have to call their Downtown office and check with intake desk there. Later, they did call back and did offer help.

"(10) Called the Information and Referral Service and was given two of the agencies mentioned above.

"(11) Called the chairman of the Bloomington Human Relations Commission and was told that a referral to the Health Services would be in order.

"Now, the rector did as he is privileged to do in such cases — that is, he took your alms, which were given to the "discretionary fund," and helped the woman in her plight.

"A couple of questions arising from this episode: How many of these agencies would you have known to call? (All are supported either through United Fund money or taxes or both). How far in this 'chain' would you have gone had you been in the woman's place? How many of these situations happen daily with forlorn and unhappy people not being met by Christian concern because we have no one in the places of distress and hurt? What can we do to be more available?"

Father Smith's last word — one parishioner with eight children offered the woman shelter; another, with seven children, found her some boots. That ends the story. It should not end our concern.

I thank Father Smith for everything — including the right to reprint his remarks.

Permission to reprint article granted by The Minneapolis Star.

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